Supreme Court, U. S.
FILED
AUG 18 1975
MICHAEL RODAK JR., CLERK

In the Supreme Court of the United States

October Term, 1975

No. 74-1110

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, *et al.*,
Petitioners,
vs.
WILLIAM E. SIMON, SECRETARY OF THE TREASURY, *et al.*,
Respondents,

No. 74-1124

WILLIAM E. SIMON, SECRETARY OF THE TREASURY, *et al.*,
Petitioners,
vs.
EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, *et al.*,
Respondents.

ON CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

BRIEF FOR AMICUS CURIAE AMERICAN HOSPITAL ASSOCIATION

ROBERT S. BROMBERG, ESQ.
1956 Union Commerce Building
Cleveland, Ohio 44115
(216) 621-0200
Attorney for American Hospital Association

Of Counsel:
JAY H. HEDGEPETH, ESQ.
BRUCE O. BAUMGARTNER, ESQ.
DOUGLAS M. MANCINO, ESQ.

THE GATES LEGAL PUBLISHING CO., CLEVELAND, OHIO—TEL. (216) 621-0647

TABLE OF CONTENTS

INTEREST OF THE AMICUS ---- 2

QUESTION TO BE DISCUSSED ---- 2

POSITION OF THE AMICUS ---- 3

SUMMARY OF ARGUMENT ---- 4

ARGUMENT ---- 12

I. REV. RUL. 69-545 IS CONSISTENT WITH THE CHARITABLE PROVISIONS OF SECTION 501 (c) (3) OF THE INTERNAL REVENUE CODE 12

A. The Term "Charitable" in Section 501(c) (3) Must Be Interpreted in Its Generally Accepted Legal Sense ---- 12

B. Rev. Rul. 69-545 Is Based Upon the Established Legal Doctrine That Promotion of Health for the Benefit of the Community Is, in the Absence of Private Benefit, a Charitable Purpose Within the Meaning of Section 501(c) (3) ---- 15

C. The Promotion of Health Is a Charitable Purpose ---- 17

D. The Relief of Poverty Is Not a Necessary Ingredient for Charitable Exemption ---- 21

E. A Nonprofit Hospital, Free of the Taint of Private Benefit or Profit, Is Charitable ---- 25

F. Rev. Rul. 69-545 Is Consistent with the Rationale for Tax Exemption under Section 501 (c) (3) ---- 29

II. THE MODERN LEGAL DEFINITION OF A CHARITABLE HOSPITAL REFLECTS THE HISTORICAL EVOLUTION OF THE VOLUNTARY NONPROFIT HOSPITAL FROM ALMSHOUSE TO COMMUNITY HEALTH FACILITY 36

A. The Law of Charity Responds to the Changing Needs of Communities and the Institutions Which Serve Them ---- 36

B. Early Hospitals Were Almshouses ---- 38

C. Voluntary Hospitals Began to Develop into Community Health Facilities During the 19th and Early 20th Centuries ---- 42

D. The Financing of Hospital Care Has Shifted to Reimbursement by Private and Governmental Third Parties ---- 47

III. REV. RUL. 69-545 IS CONSISTENT WITH FEDERAL CASE LAW PERTAINING TO TAX EXEMPTION OF NONPROFIT HOSPITALS ---- 59

A. Federal Case Law Adjudicating Exempt Status of Nonprofit Hospitals Has Been Directed Toward the Question of the Presence or Absence of Private Benefit Rather Than the Amount of Free Care ---- 59

B Rev. Rul. 69-545 Follows the Approach Taken in Federal Case Law ---- 64

IV. REV. RUL. 69-545 IS CONSISTENT WITH FEDERAL HEALTH POLICY ---- 65

V. REV. RUL. 69-545 IS CONSISTENT WITH THE LEGISLATIVE HISTORY OF SECTION 501(c)(3) ---- 68

VI. THE ISSUANCE OF REV. RUL. 69-545 WAS REQUIRED BY THE AMENDED 1959 TREASURY REGULATIONS AND BY RELEVANT ADMINISTRATIVE CONSIDERATIONS ---- 74

A. Treasury Regulations Promulgated in 1959 Recognized Broad Concepts of Charity and Required Revision of Rev. Rul. 56-185 ---- 74

B. Modification of Rev. Rul. 56-185 Was Required for Sound Administrative Reasons ---- 76

C. The Requirements of Rev. Rul. 69-545 for Providing Emergency Care and Treating Medicare and Medicaid Patients Provide a Valid Administrative Alternative to Prior Requirements for Free Care for the Poor ---- 80

1. The Emergency Room Is the Most Important Means of Access to Medical Care for the Poor ---- 81

2. Access to Hospital Care Through Medicare and Medicaid Is Important to Persons Below the Poverty Level ---- 86

CONCLUSION ---- 88

TABLE OF AUTHORITIES

Cases

American Trucking v. A.T. & S.F.R.R., 387 U.S. 397 (1967) 73

Assoc. Hosp. Services, Inc. v. City of Milwaukee, 13 Wis. 2d 447, 109 N.W.2d 271 (1961) 29

Battle Creek, Inc., Comm'r v., 126 F.2d 405 (5th Cir. 1942) 62, 63, 64

Benton County v. Allen, 170 Ore. 481, 133 P.2d 991 (1943) 57, 59

Bishop v. Treas., 37 Colo. 378, 86 P. 1021 (1906) 45

Bok v. McCaughn, 42 F.2d 616 (3d Cir. 1930) 34

Bozeman Deaconess Found. v. Ford, 151 Mont. 143, 439 P.2d 915 (1968) 36

Bradbury, In re, [1951] 1 T.L.R. 130 (Ch.D) 23

Brattleboro Retreat v. Town of Brattleboro, 106 Vt. 228, 173 A. 209 (1934) 47

Broadway Theatre League v. United States, 293 F. Supp. 346 (D.C. Va. 1968) 34

Burgess v. Four States Mem'l Hosp., 250 Ark. 485, 465 S.W.2d 693 (1971) 57

Butterworth v. Keeler, 219 N.Y. 446, 114 N.E. 803 (1916) 27

Chaplin, In re, [1932] 1 Ch.D. 115 23

Charlotte Hungerford Hosp. v. Mulvey, 26 Conn. Sup. 394, 225 A.2d 495 (1966) 37

City of Natchez v. Natchez Sanitarium Benevolent Ass'n, 2 So. 2d 798 (Miss. 1941) 84

City of Palestine v. Missouri Pacific Hospital Ass'n, 99 S.W.2d 311 (Tex. 1936) 83

City of Richmond v. Richmond Mem'l Hosp., 202 Va. 86, 116 S.E.2d 79 (1960) 26, 56, 57, 58

Cleveland Osteopathic Hosp. v. Zangerle, 153 Ohio St. 222, 91 N.E.2d 261 (1950) 47

Collier v. Lindley, 203 Cal. 641, 266 P. 526 (1928) 37

Commun. Mem'l Hosp. v. City of Moberly, 422 S.W.2d 290 (Mo. 1967) 22

Corum v. Beth Israel Medical Ctr., 359 F. Supp. 909 (S.D. N.Y. 1973) 67

Cranley, John J., Jr., 20 CCH TAX CT. MEM. 20 (1961) 61

Curtis' Est., In re, 1 Con. 471, 7 N.Y.S. 207 (Surr. Ct. 1889) 39

Dartmouth College v. Woodward, 17 U.S. (4 Wheat.) 518 (1819) 31

Davis Hospital, Inc., 4 CCH TAX CT. MEM. 312 (1945) 62, 63

Destitute of Bennington County v. Henry W. Putnam Mem'l Hosp., 135 Vt. 289, 215 A.2d 134 (1965) 56

Dingwell v. Seymour, 91 Cal. App. 483, 267 P. 327 (1928) 45

Dixon v. United States, 381 U.S. 71 (1965) 12

Duncan v. Steeper, 17 Wis. 2d 226, 116 N.W.2d 154 (1962) 20, 24, 28, 77

Elliott, In re, [1910] 102 L.T.R. (n.s.) 528 23

Ellis v. City of Grand Rapids, 257 F. Supp. 564 (S.D. Mich. 1966) 35

Estlin, In re, 72 L.J. (Ch.D.) 687 23

Euresti v. Stenner, 458 F.2d 1115 (10th Cir. 1972) 67

Evangelical Lutheran Good Samaritan Soc. v. Bd. of County Comm'rs, 219 N.W.2d 900 (N.D. 1974) 55, 56

Evangelical Lutheran Good Samaritan Soc. v. County of Gage, 181 Neb. 831, 151 N.W.2d 446 (1967) 25, 26, 54

Evans v. Newton, 382 U.S. 296 (1966) 18

Frasure, In re, [1883] 22 Ch.D. 827 23

Fribourg Navigation Co. v. Comm'r, 383 U.S. 272 (1966) 12

Friendsview Manor v. State Tax Comm'n, 247 Ore. 94, 420 P.2d 77 (1966) 34

Gerke v. Purcell, 25 Ohio St. 229 (1874) 22

German Hosp. v. Bd. of Rev., 233 Ill. 246, 84 N.E. 215 (1908) 46

Girard Trust Co. v. Comm'r, 122 F.2d 108 (3d Cir. 1941) 13

Glyn, In re, [1950] 2 All E.R. 1150 23

Gossett v. Swinney, 53 F.2d 772 (8th Cir. 1931), *cert. denied*, 286 U.S. 545 (1932) 46

Green v. Connally, 330 F. Supp. 1150 (D. D.C. 1971), *aff'd per curiam sub. nom. Coit v. Green*, 404 U.S. 997 (1971) 14, 17, 22, 37

Harding Hospital, Inc. v. United States, 505 F.2d 1068 (6th Cir. 1975) 60, 61, 62, 63

Hassett v. Assoc. Hosp. Serv. Corp., 125 F.2d 611 (1st Cir.), *cert. denied*, 316 U.S. 672 (1942) 61

Helvering v. Bliss, 293 U.S. 143 (1934) 75

Henderson's Est., In re, 17 Cal.2d 853, 112 P.2d 605 (1941) 22, 57

Hiller, In re, [1944] 1 All E.R. 480 24

Hilltop Village, Inc. v. Kirtland Independent School District, 426 S.W.2d 943 (Tex. 1968) 30

Idaho Corp. of Benedictine Sisters v. Marks, Civ. No. 1-72-169 (D. Idaho, filed Aug. 29, 1973) 87

Intercity Hosp. Assoc. v. Squire, 56 F. Supp. 472 (W.D. Wash. 1944) 61, 63

Int'l Reform Fed'n v. Dist. Unemployment Comp. Bd., 131 F.2d 337 (D.C. Cir.), *cert. denied*, 317 U.S. 693 (1942) 15, 18, 24, 37

Jackson v. Phillips, 96 Mass. (14 Allen) 539 (1867) 19

Jackson County v. State County Comm'r, 521 S.W.2d 378 (Mo. 1975) 55, 77, 84

James, In re, [1932] 2 Ch. 25 23

Jefferson v. United States, 178 F.2d 518 (4th Cir. 1959), *aff'd sub. nom. Feres v. United States*, 340 U.S. 135 (1960) 74

Kenner, William H., 20 CCH TAX CT. MEM. 185 (1961), *aff'd*, 318 F.2d 632 (7th Cir. 1963) 61

La Crescent Constant Care Center, Inc. v. Minnesota, 222 N.W.2d 87 (Minn. 1974) 86, 87

Lewis, In re, [1954] 3 All E.R. 257 23

Lots 8 and 9, In re, 27 Minn. 460 (1881) 41

Lorain Avenue Clinic, 31 T.C. 141 (1958) 60, 62

Lucas, In re, [1922] 2 Ch.D. 52 23

Maynard Hosp., Inc., 52 T.C. 1006 (1969) 60, 61

Mayor and Aldermen of City of Vicksburg v. Vicksburg Sanitarium, 117 Miss. 709, 78 So. 702 (1918) 40

McDonald v. Mass. Gen'l Hosp., 120 Mass. 432, 21 Am. Rep. 529 (1876) 27, 59

Mem'l Hosp. v. Maricopa County, 415 U.S. 250 (1974) 51, 52, 80

Miami Retreat Found. v. Ervin, 62 So. 2d 748 (Fla. 1952) 55

Milwaukee Protestant Home v. City of Milwaukee, 41 Wis. 2d 284, 164 N.W.2d 289 (1969) 25, 28

New England Sanitarium v. Inhabitants of Stoneham, 205 Mass. 335, 91 N.E. 385 (1910) ---- 46

Nuns of Third Order of St. Dominic v. Younkin, 118 Kan. 554, 235 P. 869 (1925) ---- 45

O'Brien v. Physicians' Hosp. Assoc., 96 Ohio St. 1, 116 N.E. 975 (1917) ---- 40, 47

Olney, Robert C., 17 CCH Tax Ct. Mem. 982 (1958) ---- 62, 63

Order of Ry. Conductors v. Swan, 329 U.S. 520 (1947) ---- 73

Ould v. Washington Hosp., 95 U.S. 303 (1877) ---- 17

Paschal v. Acklin, 27 Tex. 173 (1863) ---- 21

Pemsel, Comm'rs v., [1891] A.C. 531, 3 Tax Cas. 53 ---- 18

Pennsylvania Co. for Ins. v. Helvering, 66 F.2d 284 (D.C. Cir. 1933) ---- 13

People ex rel. Doctors Hosp., Inc. v. Sexton, 267 App. 736, 48 N.Y.S.2d 201 (1944), *aff'd mem.*, 295 N.Y. 553, 64 N.E.2d 273 (1945) ---- 26

Peters, Isabel, 21 T.C. 55 (1953) ---- 71

Pollack v. Farmers' Loan & Trust Co., 157 U.S. 429, *aff'd on reh.*, 158 U.S. 601 (1895) ---- 68

Prange's Will, In re, 208 Wis. 404, 243 N.W. 488 (1932) ---- 41

Red Lion Broadcasting Co. v. F.C.C., 395 U.S. 367 (1969) ---- 73

Richardson v. Exec. Comm. of Baptist Conv., 176 Ga. 705, 169 S.E. 18 (1933) ---- 40

Riverview Hosp. v. City of Tomahawk, 243 Wis. 581, 11 N.W.2d 188 (1943) ---- 29

Robinson, In re, [1951] Ch. 198 ---- 23

Roadley, In re, [1930] 1 Ch.D. 524 ---- 23

Rueda v. Union Pac. Ry., 180 Ore. 133, 175 P.2d 778 (1946) ---- 29

Rust's Est., In re, 168 Wash. 344, 12 P.2d 396 (1932) 22

Salem Lutheran Home Assoc., 2 CCH Tax Ct. Mem. 157 (1943) ---- 62

Samuel Friedland Found. v. United States, 144 F. Supp. 74 (D. N.J. 1956) ---- 13

Santa Rosa Infirmary v. City of San Antonio, 259 S.W. 926 (Comm. App. Tex. 1924) ---- 45, 47

Sisters of Third Order of St. Francis v. Bd. of Rev., 231 Ill. 317, 83 N.E. 272 (1907) ---- 45, 46

So. Methodist Hosp. and Sanitarium v. Wilson, 51 Ariz. 424, 77 P.2d 458 (1938) ---- 27, 54, 57, 59

Sonora Comm. Hosp., 46 T.C. 519 (1966), *aff'd per curiam*, 397 F.2d 814 (9th Cir. 1968) ---- 60, 62

State v. Browning, 192 Minn. 25, 255 N.W. 254 (1934) ---- 59

State v. Collector of Chatham, 52 N.J.L. 373, 20 A. 292 (1890) ---- 46

State ex rel. Alexian Bros. Hosp. v. Powers, 74 Mo. 476 (1881) ---- 46

State ex rel. Cunningham v. Bd. of Assessors, 52 La. Ann. 223, 26 So. 872 (1898) ---- 45

Swearingen v. United States, 161 U.S. 446 (1895) ---- 14

S.W. Osteopathic Sanitarium v. Davis, 242 P. 1033 (Okla. 1926) ---- 40

Todd v. Citizens Gas Co., 46 F.2d 855 (7th Cir.), *cert. denied*, 283 U.S. 852 (1931) ---- 37

Tollinger's Est., In re, 349 Pa. 393, 37 A.2d 500 (1944) 17

Trinadad v. Sagrada Orden, 263 U.S. 578 (1924) ---- 28

United Presbyterian Homes, In re, 428 Pa. 145, 236 A.2d 776 (1968) ---- 17, 55

United States v. Wong Kim Ark., 169 U.S. 649 (1898) 14

Wall, In re, [1889] 42 Ch. 510 ---------- 23

Walz v. Tax Comm'n, 397 U.S. 664 (1970) ---------- 31

Weiss v. Swedish Hosp., 16 Wash. 2d 446, 133 P.2d 978 (1943) ---------- 26, 57

Y.M.C.A. v. Lancaster County, 106 Neb. 105, 182 N.W. 593 (1921) ---------- 54

Y.M.C.A. v. Los Angeles County, 35 Cal. 2d 760, 221 P.2d 47 (1950) ---------- 31

Zuber v. Allen, 396 U.S. 168 (1969) ---------- 73

Constitutional Provisions

U.S. CONST., amend. V ---------- 11, 78

Statutes Currently in Force

26 U.S.C.

§170 ---------- 4, 34, 70

§501(a) ---------- 3

§501(c)(3) ---------- 2, *et passim*

§2055(a) ---------- 33

§2522(a) ---------- 33

§7805 ---------- 12, 71

42 U.S.C.

§139a(a)(23) ---------- 86

§291 ---------- 66, 67

§1395 ---------- 66, 86, 87

§1396 ---------- 66, 86, 87

District of Columbia Unemployment Compensation Act ---------- 37

Social Security Act of 1935 ---------- 69

Social Security Amendments of 1939 ---------- 69

Tax Reform Act of 1969 ---------- 13, 72

Statutes Not in Force

Act of Aug. 15, 1894, ch. 349, 28 Stat. 553 ---------- 68

Act of Aug. 5, 1909, ch. 6, 36 Stat. 11 ---------- 21, 68

Act of Oct. 3, 1913, ch. 16, 38 Stat. 114 ---------- 69

Revenue Act of 1918, ch. 18, 40 Stat. 1057 (Feb. 24, 1919) ---------- 13, 70

Revenue Act of 1921, ch. 136, 42 Stat. 227 (Nov. 23, 1921) ---------- 70

Statute of Elizabeth, Stat. 43 Eliz. I, ch. 4 (1601) ---------- 17, 18, 22, 23

Treasury Regulations

26 C.F.R.

§1.501(c)(3)-1(b) ---------- 62, 74

§1.501(c)(3)-1(c) ---------- 62

§1.501(c)(3)-1(d)(2) ---------- 8, 13, 23, 71, 75

§1.509-2(a) ---------- 33

§53.4942(a)-3(a)(6) ---------- 33

§53.4945-5(a)(5) ---------- 33

Proposed Treasury Regulation §1.501(c)(3)-1(b), 21 Fed. Reg. 460 (1956) ---------- 74

Proposed Treasury Regulation §1.501(c)(3)-1(b), 24 Fed. Reg. 1431 (1959) ---------- 74

Treasury Regulation 118, §39.101(6)-1(b) (1953) ---------- 74

Revenue Rulings and Other Determinations

I.T. 1800, II-2 CUM. BULL. 152 (1923) ---------- 70, 71

Rev. Rul. 55-656, 1955-2 CUM. BULL. 262 ---------- 20

Rev. Rul. 56-185, 1956-1 CUM. BULL. 202 ---------- 2, *et passim*

Rev. Rul. 59-310, 1959-2 CUM. BULL. 146 ---------- 71

Rev. Rul. 64-174, 1964-1 CUM. BULL. 183 ---------- 34

Rev. Rul. 64-275, 1964-2 CUM. BULL. 142 ---------- 34

Rev. Rul. 65-191, 1965-1 CUM. BULL. 157 ---------- 34

Rev. Rul. 65-271, 1965-2 CUM. BULL. 161 ---------- 34

Rev. Rul. 65-298, 1965-2 CUM. BULL. 163 ---------- 20

Rev. Rul. 66-46, 1966-1 CUM. BULL. 133 ---------- 34

Rev. Rul. 66-146, 1966-1 CUM. BULL. 136 ---------- 34

Rev. Rul. 66-323, 1966-2 CUM. BULL. 216 ---------- 20

Rev. Rul. 67-292, 1967-2 CUM. BULL. 184 ---------- 34

Rev. Rul. 67-325, 1967-2 CUM. BULL. 113 ---------- 14

Rev. Rul. 67-391, 1967-2 CUM. BULL. 190 ---------- 38

Rev. Rul. 68-70, 1968-1 CUM. BULL. 194 ---------- 34

Rev. Rul. 68-73, 1968-1 CUM. BULL. 251 ---------- 20

Rev. Rul. 68-164, 1968-1 CUM. BULL. 252 ---------- 33

Rev. Rul. 69-43, 1969-1 CUM. BULL. 310 ---------- 71

Rev. Rul. 69-174, 1969-1 CUM. BULL. 149 ---------- 20

Rev. Rul. 69-525, 1969-2 CUM. BULL. 115 ---------- 20

Rev. Rul. 69-545, 1969-2 CUM. BULL. 117 ---------- 2, *et passim*

Rev. Rul. 70-533, 1970-2 CUM. BULL. 112 ---------- 38

Rev. Rul. 70-590, 1970-2 CUM. BULL 116 ---------- 20, 38

Rev. Rul. 70-640, 1970-2 CUM. BULL. 117 ---------- 34, 38

Rev. Rul. 71-460, 1971-2 CUM. BULL. 231 ---------- 32

Rev. Rul. 71-545, 1971-2 CUM. BULL. 235 ---------- 34

Rev. Rul. 72-124, 1972-1 CUM. BULL. 145 ---------- 20

Rev. Rul. 72-209, 1972-1 CUM. BULL. 148 ---------- 20, 38

Rev. Rul. 72-228, 1972-1 CUM. BULL. 148 ---------- 38

Rev. Rul. 72-560, 1972-2 CUM. BULL. 248 ---------- 38

Rev. Rul. 73-313, 1973-2 CUM. BULL. 174 ---------- 20

Rev. Rul. 73-569, 1973-2 CUM. BULL. 178 ---------- 20, 38

Rev. Rul. 75-197, 1975-22 INT. REV. BULL. 8 ---------- 20

Rev. Rul. 75-198, 1975-22 INT. REV. BULL. 9 ---------- 20

Rev. Proc. 59-31, 1959-2 CUM. BULL. 949 ---------- 33

Rev. Proc. 71-39, 1971-2 CUM. BULL. 575 ---------- 38

S.M. 2160, III-2 CUM. BULL. 151 (1924) ---------- 71

Sol. Op. 159, III-1 CUM. BULL. 480 (1924) ---------- 13, 71

T.D. 6391, 24 Fed. Reg. 5217 (1959) ---------- 13, 71, 74

Other Authorities

AHA Statement, HEARINGS ON H.R. 13270 BEFORE HOUSE COMM. ON WAYS AND MEANS, 91st Cong., 1st Sess. (1969) ---------- 77

1973 AHA GUIDE TO THE HEALTH FIELDS (Aug. 1973) ---------- 52, 85

AMERICAN ASSOC. OF FUND RAISING COUNCIL, INC., GIVING U.S.A. (1973) ---------- 51

Ann., *Receipt of Pay from Beneficiaries as Affecting Tax Exemption of Charitable Institutions*, 37 A.L.R.3d 1191 (1971) ---------- 36

Atiyah, *Public Benefit of Charities*, 21 MOD. L. REV. 138 (1958) ---------- 23

Atiyah, *The Aged, Impotent and Poor*, 18 MOD. L. REV. 76 (1955) ---------- 23

BAEHR, G., *Medical Care: Old Goals and New Horizons*, 3 MEDICAL CARE AND TRANSITION (1967) -- 48

BASIC FACTS ON THE HEALTH INDUSTRY, HOUSE COMM. ON WAYS AND MEANS, 91st Cong., 1st Sess. (1971) ---------- 64

BELKNAP, I., AND J. STEINLE, THE COMMUNITY AND ITS HOSPITALS (1963) ---------- 43

BLACK, H., A TREATISE ON THE LAW OF INCOME TAXATION (2d ed. 1915) ---------- 21

BOGERT, G., THE LAW OF TRUSTS AND TRUSTEES (2d ed. 1964) ---------- 17, 19, 21, 36

BROMBERG, R., *Charity and Change: Current Problems of Tax Exempt Organizations in Perspective*, TAX PROBLEMS OF CHARITIES 1970, at 249 (Webster & Lehrfeld eds. 1970) ---------- 31, 37, 38

Bromberg, Non-profit Homes for the Aged: An Analysis of Their Current Tax Exempt Status, 38 J. TAX. 54 (1973) ---------- 31

Bromberg, *The Charitable Hospital*, 20 CATH. U. L. REV. 237 (1970) ---------- 39, 59

Brunyate, *The Legal Definition of Charity*, 61 L. Q. REV. 268 (1945) ---------- 19, 24

Cantor, *The Law and the Poor People's Access to Health Care*, 35 LAW & CONTEM. PROB. 901 (1970) ---------- 49, 52, 79, 82, 83, 86, 87

Charitable Purposes, 106 SOL. J. 969 (1969) ---------- 22

14 C.J.S. *Charities* (1939) ---------- 22, 25

84 C.J.S. *Taxation* ---------- 25

COMM'N ON HOSPITAL CARE, HOSPITAL CARE IN THE UNITED STATES (1947) ---------- 38, 41, 42, 43, 66

COMMITTEE ON LAW AND PRACTICE, REPORT RELATING TO CHARITABLE TRUSTS CMD. NO. 8710 (1952) 24

26 Cong. Rec. 1727 (1894) ---------- 68

44 Cong. Rec. 4150 (1909) ---------- 69

44 Cong. Rec. 4151 (1909) ---------- 68

65 Cong. Rec. 8171 (1924) ---------- 71

DAVIS, M., CLINICS, HOSPITALS AND HEALTH CENTERS (1927) ---------- 43

DENSON, BALAMUTT AND SHAPIRO, PREPAID MEDICAL CARE AND HOSPITAL UTILIZATION (1958) ------ 48

DEPT. HEALTH, EDUC. & WELFARE, REPORT OF SECRETARY'S ADVISORY COMM. ON HOSP. EFFECTIVENESS (1968) ---------- 48

Eaton, *Charitable Foundations Making Grants Abroad*, 17 TAX L. REV. 41 (1961) ---------- 33

Exemption of Educational, Philanthropic and Religious Institutions from State Real Property Taxes, 64 HARV. L. REV. 288 (1950) ---------- 30, 31

Factors Affecting the Costs of Hospital Care, 1 FINANCING HOSPITAL CARE IN THE UNITED STATES 9 (J. Hayes, ed. 1954) ---------- 39, 41, 48, 49

FISCH, E., D. FREED, AND E. SCHACHTER, CHARITIES AND CHARITABLE FOUNDATIONS (1974) ----19, 39, 44

GUIDE TO CONSUMER MARKETS, CONFERENCE BOARD REPORT, No. 67 ---------- 49

HALSBURY'S LAWS OF ENGLAND (4th ed. 1974) ----- 24

HAYT, HAYT & GROESCHEL, LAW OF HOSPITAL, PHYSICIAN AND PATIENT (2d ed. 1952) ---------- 54, 58

HEARINGS ON CONDITIONS AND PROBLEMS OF THE NATION'S NURSING HOMES, SUBCOMM. ON LONG-TERM CARE, SPECIAL COMM. ON AGING, U.S. SEN. (Part 2), 89th Cong., 1st Sess. (1965) ---------- 51

HEARINGS ON MEDICARE AND MEDICAID BEFORE THE SUBCOMM. ON MEDICARE-MEDICAID OF THE SENATE COMM. ON FINANCE (PART 2), 91st Cong., 2d Sess. (1970) ---------- 51

Horty, *How Does Surplus Affect Tax Status*, 107 MOD. HOSP. 40 (July 1966) ---- 83

Horty, *Public Purpose is the Key to Tax Exemptions*, 106 MOD. HOSP. 60, 62 (March 1966) ---- 35

HOSPITAL LAW MANUAL (1973) ---- 58, 83

HOYT, CONDITION CRITICAL: OUR HOSPITAL CRISIS (1966) ---- 83

H.R. 1, 94th Cong., 1st Sess. (1975) ---- 66

H.R. 2222, 93rd Cong., 2nd Sess. (1974) ---- 66

H.R. 3870, 93rd Cong., 2nd Sess. (1974) ---- 66

H.R. 12684, 93rd Cong., 2nd Sess. (1974) ---- 66

H.R. 13270, 91st Cong., 1st Sess. (1969) ---- 72, 73

H.R. REP. No. 1540, 74th Cong., 1st Sess. (1935) ---- 70

H.R. REP. No. 1860, 75th Cong., 3rd Sess. (1938) ---- 33, 34

H.R. REP. No. 91-413 (Part 1), 91st Cong., 1st Sess. (1969) ---- 72, 80

Humanitarian Approach to Taxation of Homes for the Aged, 4 WILLAMETTE L. J. 504 (1967) ---- 30, 31, 32, 36

KLARMAN, H., THE ECONOMICS OF HEALTH (1965) ---- 48

KNOWLES, J., HOSPITALS, DOCTORS AND THE PUBLIC INTEREST (1965) ---- 38

LETOURNEAU, C., HOSPITAL TRUSTEESHIP (1959) ---- 38

MARTS, THE GENEROSITY OF AMERICANS (1966) ---- 38

MCNERNEY, *Health Research and Educational Trusts*, 1 HOSPITAL AND MEDICAL ECONOMICS 92 (1962) ---- 41, 43

Medical Care in Transition, 3 AM. J. PUBL. HEALTH 414 (1966) ---- 82

Mueller, *Private Health Insurance in 1973: A Review of Coverage, Enrollment and Financial Experience*, 38 SOC. SEC. BULL. 21 (Feb. 1975) ---- 48, 49, 50

NATIONAL ADVISORY COMM'N ON HEALTH FACILITIES: A REPORT OF THE PRESIDENT (1968) ---- 82

NUMBER OF RECIPIENTS AND AMOUNTS OF PAYMENTS UNDER MEDICAID 1970, DHEW Publ. No. (SRS) 73-03153MCSS Report B-41 (CY 70) ---- 49

40 Op. ATT'Y GEN. 286 (1947) ---- 70

Pierson, *An Examination of Obsolescence*, 48 HOSPITALS 52 (Feb. 1, 1974) ---- 78

Reiling, *Federal Taxation: What Is a Charitable Organization?*, 44 A.B.A.J. 525 (1958) ---- 70

Renovation Projects Swell Total Hospital Construction, 48 HOSPITALS 51 (Feb. 1, 1974) ---- 78

REPORT OF THE STAFF OF THE COMM. ON FIN., MEDICARE AND MEDICAID: PROBLEMS, ISSUES AND ALTERNATIVES, 91st Cong., 1st Sess. (1970) ---- 61, 72

RESTATEMENT (SECOND) OF TRUSTS (1959) ---- 18, 19

Sacks, *The Role of Philanthropy: An Institutional View*, 46 VA. L. REV. 516 (1960) ---- 20

SANDS, D., STATUTES AND STATUTORY CONSTRUCTION (4th ed. 1973) ---- 14

Scarce Medical Resources, 69 COLUM. L. REV. 620 (1969) ---- 80

SCOTT, A., THE LAW OF TRUSTS (3d ed. 1967) ---- 17, 19, 22, 47

Stone, *Federal Tax Support of Charities and Other Exempt Organizations: The Need For A National Policy*, 20 So. CAL. TAX. INST. 54 (1968) ---- 35

S. 3, 94th Cong., 1st Sess. (1975) ---- 66

S. 44, 93rd Cong., 2nd Sess. (1974) ---- 66

S. 2513, 93rd Cong., 2nd Sess. (1974) ---- 66

S. 2970, 93rd Cong., 2nd Sess. (1974) ---- 66

S. 33286, 93rd Cong., 2nd Sess. (1974) ---- 66

S. REP. No. 91-552, 91st Cong., 1st Sess. (1969) ---- 73

SUMMARY OF H.R. 13270, HOUSE COMM. ON WAYS AND MEANS, 91st Cong., 1st Sess. 23 (1969) --- 72, 80

Taxation—Charitable Exemptions From Real Estate Taxes—What is a Charity, 17 DEPAUL L. REV. 433 (1968) ---------- 55

U.S. DEPT. OF HEW, PUBLIC HEALTH SERVICES, HEALTH FACILITIES CONSTRUCTION: BY TYPE OF FUNDS (1920-1974) (HILL-BURTON FEDERAL GRANTS) ---------- 67

Walls, *Cost Reimbursement Worsens Capital Crisis*, 46 HOSPITALS 81 (March 1, 1972) ---------- 51

Worthington, *National Health Expenditures, 1929-1974*, 38 Soc. SEC. BULL. 3 (1975) ---------- 67

ZOLLMANN, C., AMERICAN LAW OF CHARITIES (1924) ---------- 22, 36, 47

In the Supreme Court of the United States

October Term, 1975

No. 74-1110

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, *et al.*,
Petitioners,

vs.

WILLIAM E. SIMON, SECRETARY OF THE TREASURY, *et al.*,
Respondents,

No. 74-1124

WILLIAM E. SIMON, SECRETARY OF THE TREASURY, *et al.*,
Petitioners,

vs.

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, *et al.*,
Respondents.

ON CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

BRIEF FOR AMICUS CURIAE AMERICAN HOSPITAL ASSOCIATION

INTEREST OF THE AMICUS

This Brief is presented on behalf of the American Hospital Association (hereinafter "AHA") in opposition to the brief submitted on behalf of the Eastern Kentucky Welfare Rights Organization, et al.[1] The consents of the parties to the filing of this Brief have been filed with the Clerk of the Court.

AHA is an association whose membership includes more than 3,000 voluntary nonprofit hospitals. The interest of AHA in this case arises from the fact that these hospitals are the organizations whose charitable status forms the underlying issue in this case, and whose tax-exempt status is determined alternatively under the criteria of *Rev. Rul. 56-185*, 1956-1 CUM. BULL. 202 or the criteria of *Rev. Rul. 69-545*, 1969-2 CUM. BULL. 117.

Plaintiffs are seeking to have the criteria for exemption in *Rev. Rul. 69-545* declared invalid. However, AHA believes that that Ruling, upheld in the decision below, is a valid interpretation of the charitable provisions of section 501 (c) (3) of the Internal Revenue Code of 1954.[2]

QUESTION TO BE DISCUSSED

The substantive issue in this case is whether the criteria set forth in *Rev. Rul. 69-545* for qualification of nonprofit hospitals as tax-exempt organizations are consistent with section 501(c) (3). While AHA recognizes that there are also important procedural issues involved in this case, AHA will only discuss this question.

---

[1] For convenience and consistency with the parties' briefs, hereinafter petitioners in 74-1110 will be called "plaintiffs" and petitioners in 74-1124 will be called "defendants." Plaintiffs' Brief is referred to as "Pl. Br."

[2] Hereinafter referred to as Code. All citations to Code, unless otherwise indicated, will be made to the Internal Revenue Code of 1954, as amended, 26 U.S.C. §1 et seq.

POSITION OF THE AMICUS

The voluntary nonprofit member hospitals of the AHA serve the health needs of communities throughout the United States. All of these hospitals are believed to be exempt from taxation under section 501(a) as charitable organizations described in section 501(c) (3) and as such recognize their obligation to provide services for the entire community, including its less fortunate members.

Plaintiffs' substantive position seems to be that *Rev. Rul. 69-545* is invalid because it is contrary to the charitable provisions of section 501(c) (3). The basis for this position appears to be that this Ruling allegedly eliminates any requirement of *Rev. Rul. 56-185* that nonprofit hospitals must provide "free" care for indigents as a condition to qualify for tax exempt status under section 501 (c) (3). While AHA shares plaintiffs' concern for adequate health care for the poor, it believes that the Ruling in question not only is a valid interpretation of the charitable provisions of section 501(c) (3), but also that it will, in fact, provide more effective access to hospital care for indigent persons than the standards supported by plaintiffs.

To the extent that *Rev. Rul. 56-185* predicates tax exemption of nonprofit hospitals primarily on relieving poverty, it is not consistent with the prevailing view of the law and its standards are not susceptible to objective and consistent application. On the other hand, the promotion of health rationale of *Rev. Rul. 69-545* more accurately reflects contemporary standards for tax exemption of such institutions and is therefore in accord with section 501(c) (3), the regulations and the case law, including the law of charitable trusts which forms the basis for Federal income tax exemption. Moreover, *Rev. Rul. 69-545* sets forth *alternative* criteria which are more susceptible

to objective and consistent application than the uncertain, inadministrable and superannuated free-care standards supported by plaintiffs.

SUMMARY OF ARGUMENT

The substantive issue in this case is simply one of statutory construction—whether *Rev. Rul. 69-545* is consistent with section 501(c)(3), or in other words, whether the Commissioner of Internal Revenue (hereinafter "Commissioner") was acting within the scope of his authority in issuing *Rev. Rul. 69-545*. Section 501(c)(3) provides tax exemption to organizations which are organized and operated exclusively for "religious, charitable, scientific, literary, educational purposes, or for the prevention of cruelty to children or animals." Under section 170, contributions to such organizations are also deductible in computing taxable income.

In 1956 under Treasury regulations then in effect, the Commissioner had issued *Rev. Rul. 56-185* which required, as a criterion for tax exemption under section 501(c)(3), that a voluntary nonprofit hospital "must be operated to the extent of its financial ability for those not able to pay for the services rendered." In 1969 *Rev. Rul. 69-545* was issued to provide alternative criteria for determining whether voluntary non-profit hospitals are organized and operated for exempt purposes and to modify the free care criterion of *Rev. Rul. 56-185*.

In issuing *Rev. Rul. 69-545*, the Commissioner recognized that in accordance with the Treasury regulations which had been revised and expanded in 1959, the term "charitable" is used in section 501(c)(3) in its generally accepted legal sense under the law of charity and charitable trusts and is not restricted to organizations relieving

poverty through the rendition of free or below cost care. The Ruling is based upon the established legal doctrine that the promotion of health for the benefit of the community is, in the absence of private benefit or profit, a charitable purpose within the meaning of section 501(c)(3). Because the criteria set forth in *Rev. Rul. 69-545* constitute an interpretation of "charitable" which is consistent with its generally accepted legal sense, the issuance of that Ruling was within the scope of the Commissioner's authority, and the decision of the Court of Appeals below should be upheld.

Central to the law of charity and charitable trusts, and thus to section 501(c)(3), is the concept that charitable purposes must be broadly defined to include all purposes which promote man's well-being and which are beneficial to the community. One such purpose which has been recognized as charitable under English and American law is the relief of the distress of sick and aged persons, or in other words, the promotion of health. In the eyes of the law, because the act of caring for the sick or aged is, in and of itself, an act of compassion or "charity," nonprofit organizations engaged in ministering to the needs of this charitable class are not also required to render assistance to the poor in order to be classified as charitable. For this reason, the law has recognized that a nonprofit hospital, whose assets are devoted to the care of the sick and whose operations are free of any private benefit or profit to its founders or those in control, is a charitable organization.

Plaintiffs have attempted to refute these established legal principles by asserting that tax exemption of nonprofit hospitals must be based exclusively on their lessening of burdens of government through the provision of free care to the poor. Such assertion is inaccurate and does not reflect the prevailing legal view. Lessening of burdens of government is but one of two rationale underly-

ing the tax exemption of charitable institutions. The prevailing and more logical view is that governments grant tax exemption to encourage humanitarian and other socially useful functions by the private sector.

The criteria for exemption of nonprofit hospitals under *Rev. Rul. 69-545* is, in fact, supported under both rationale. The relief of the distress of the sick is certainly a humanitarian and socially useful activity. At the same time, voluntary nonprofit hospitals lessen the burdens of government because without them government would be forced to assume the entire responsibility for delivering hospital care.

Because the law of charity is centered around this concept of community benefit, it is in constant motion and is ever changing to meet the shifting needs and demands of society, lest it become stagnant. *Rev. Rul. 69-545* does no more than reflect certain basic changes in the law of charity engendered by the law's response to historic changes in the nature, function, and financing of the hospital as an institution in American society.

Our early "charitable" hospitals grew out of the almshouses and pest houses of the 18th Century. While they provided a refuge for the poor and unwanted, their unsanitary and primitive conditions discouraged their widespread uses by all but the less fortunate members of society. The early legal definition of a charitable hospital reflected these conditions by characterizing it as an institution which was (1) primarily concerned with indigents, (2) precluded from serving any substantial number of paying patients, (3) required to provide free care, and (4) funded by charitable contributions to pay for such care.

During the 19th and into the 20th Century, hospital conditions began to improve and hospitals began to evolve into centralized health facilities for the entire community.

Pay patients began to make substantial use of these facilities for the first time, and the payments hospitals received for their care, which generally exceeded the cost of such care, were added to charitable endowments to underwrite free care for the poor. The law of charity reflected these changes by recognizing that a charitable hospital could serve "rich and poor alike," thus permitting hospitals to treat pay patients without risking their charitable status.

By the last half of the 20th Century, other important changes had occurred. Most important was the shift in the funding of hospital care to reimbursement by both private and governmental third parties. In the governmental sector there was a rapid growth in social welfare legislation to provide government funding of health care for the poor through reimbursement to providers. This resulted in a decline in the percentage of patients who lacked some form of private or public coverage and therefore resulted in fewer persons who required free care. At the same time, the ability of the charitable hospital to underwrite the cost of free care for those without coverage was also declining. The free care test for charitable hospitals, prevalent under prior law, fell into discredit as anachronistic and inadministrable in light of such recent social and economic changes, and the charitable status of nonprofit hospitals was recognized despite the absence of free care.

This also reflects the dedication of the Federal government to a policy of improving the quality of health care for all Americans. However, the implementation of this objective is encompassed in a Federal policy directed toward providing reimbursement of health services for persons unable to pay. Programs such as Medicare and Medicaid, and proposals for national health insurance, are all directed toward, and examples of, the Federal reimbursement policy. Federal policy does not, as plaintiffs contend, require hospitals to provide free, unreimbursed care. Such

a policy could only perpetuate the inequities resulting from continued dependence of the poor on the dole.

The approach under *Rev. Rul. 69-545* to exemption of nonprofit hospitals under section 501(c)(3) is also consistent with Federal case law. This body of law has never addressed itself directly to the question before the Court, namely, whether the delivery of free care is an absolute requirement for a tax-exempt hospital. Rather it has concerned itself with the question of whether a particular institution is operating in the public interest or in furtherance of private interests. In providing criteria for distinguishing the operations of a nonprofit hospital in the public interest from those furthering private interests, *Rev. Rul. 69-545* is consistent with the thrust of Federal case law.

Rev. Rul. 69-545 is also consistent with the legislative history of section 501(c)(3) which indicates an intent to cover organizations operating for humanitarian purposes, such as relief of the distress of the sick and aged. The legislative "inaction" cited by plaintiffs does not indicate a contrary policy and does not support plaintiffs' attempt to restrict the charitable exemption under section 501(c)(3) to relief of the poor. Such inaction, to the extent it may be relevant to statutory construction, more accurately indicates a Congressional desire to leave the administration of the charitable provisions of the Code to the Commissioner.

Plaintiffs also discount the obligation of the Commissioner to revise the criteria of rulings which antedate the promulgation of Treas. Reg. §1.501(c)(3)-1(d)(2) and which no longer comport with the expanded definition of the term "charitable" contained therein. *Rev. Rul. 56-185*, published under earlier, more restrictive regulations and requiring relief of poverty as a condition to exemption, was one such ruling.

Furthermore, modification of *Rev. Rul. 56-185* was required because of the serious administrative inadequacies resulting from its test of free care. The practical effect of this test was to substitute the judgment of an examining agent over that of hospital administrators, trustees and local health councils with respect to determining a hospital's priorities for utilizing any so-called surplus funds between free care for the poor and other programs beneficial to the community.

In issuing alternate criteria for exemption in *Rev. Rul. 69-545*, the Commissioner did not, as plaintiffs contend, ignore the plight of the poor upon which the earlier ruling had focused. Instead, *Rev. Rul. 69-545* makes a contribution toward improving the access of the poor to hospital care which is at least, if not more, effective than the ambiguous "extent of financial ability" standard of free care in *Rev. Rul. 56-185*. Hospitals seeking to qualify under *Rev. Rul. 69-545* must establish that they maintain an emergency room which is available to all, regardless of ability to pay, and adhere to a policy of not refusing admission to Medicare and Medicaid patients for inpatient care. These conditions, not found under prior rulings, insure that an exempt hospital will operate for the benefit of the entire community, including the poor.

Finally it must be noted that the one question underlying this litigation for which no adequate answer has been offered is—where is the money to come from to pay for the 40 million persons alleged by plaintiffs to be in need of free hospital care? Without a satisfactory answer to this question, a reversal of the lower court decision would be tantamount to a judicially enacted program of national health insurance *without funding*. The traditional sources which enabled our voluntary nonprofit hospitals to serve the indigent without charge—philanthropy, patient payments of rates in excess of cost, and surpluses generated

from hospital operations—are neither adequate, and in many cases no longer available.

First, philanthropy, although still an important source of capital, is no longer the significant source of underwriting free care. The simple fact is that contributors generally give to the hospital of their choice out of a desire to improve its facilities and its ability to deliver the highest quality of care to the community which benefit the rich and poor alike, rather than for the expansion of services exclusively for the poor. A reversal of the lower court decision will discourage, rather than encourage, the already dwindling funds available through philanthropy.

Second, the percentage of hospital expenditures reimbursed on the basis of cost (from which the cost of indigent care must be excluded) was 72.8% in 1972, and has been steadily increasing. This leaves the modern hospital with a steadily declining base for charging fees in excess of cost in order to underwrite the cost of free care; and the self-pay and commercially insured patients that would have to bear these costs are already painfully overburdened.

Third, in the case of those hospitals that manage to generate an illusory appearance of a surplus, the replacement of facilities and equipment in the current inflationary period can easily change their cash flow position to the red. If the same hospitals were treated as non-exempt, the deductions taken for depreciation under proper accounting methods would rarely keep up with increases in the cost of replacement.

Fourth, even in those cases where a hospital may be in a favorable cash position, it nevertheless will still have other priorities to be considered in determining how it can best serve the community. The devotion of any surplus by a hospital "to the extent of its financial ability" exclusively to indigent care can be to the detriment of its

ability to provide the overall community with other needed services, such as medical education, training and research, the purchase of new equipment developed under modern technology, the implementation of new medical techniques, and the establishment of other facilities needed by the community, such as those for mental health and drug abuse.

Thus, the picture painted by plaintiffs of our voluntary, nonprofit hospitals as institutions unconcerned with the plight of the poor is unfounded. Most of our private nonprofit hospitals, particularly those in communities lacking any public facilities, do admit and treat persons unable to pay. To the extent that there may be hospitals that do not provide the amount of free care desired by plaintiffs, it is not out of a lack of compassion, but because of economic necessity and a concern for the greater good of the rest of the community which must also be served by these institutions.

Pushed to its logical conclusion, plaintiffs' position would require nonprofit hospitals to underwrite the equivalent of a program of national health insurance. However essential Federal income tax exemption may be, it is simply not the equivalent of "just compensation" within the purview of the Fifth Amendment. U.S. CONST. amend. V. A judicial adoption of plaintiffs' position could effectively repeal the application of section 501(c)(3) to nonprofit hospitals.

ARGUMENT

I. REV. RUL. 69-545 IS CONSISTENT WITH THE CHARITABLE PROVISIONS OF SECTION 501(c)(3) OF THE INTERNAL REVENUE CODE.

Rev. Rul. 69-545 provides that nonprofit hospitals which satisfy certain specified criteria shall be considered "charitable" and thus tax-exempt under section 501(c)(3). The authority for the promulgation of all revenue rulings derives from section 7805 of the Code.[3] By virtue of that section, the Commissioner may lawfully issue any revenue ruling interpreting a provision of the Code,[4] or reflecting a change or modification of existing rulings,[5] provided such interpretations or modifications are consistent with and supported by law. *Rev. Rul. 69-545* therefore must be held lawful and valid, and thus within the scope of the Commissioner's authority under section 7805, if it is consistent with the legal meaning of the term "charitable" as used in section 501(c)(3).

A. The Term "Charitable" in Section 501(c)(3) Must Be Interpreted in Its Generally Accepted Legal Sense.

Section 501(c)(3) of the Internal Revenue Code of 1954 exempts from Federal income taxation organizations

> "operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or for the prevention of cruelty to children or animals, no part of the net earnings of which inures

[3] Under section 7805 the Secretary or his delegate (the Commissioner) is authorized to "prescribe all needful rules and regulations for the enforcement of this title, including all rules and regulations as may be necessary by reason of any alteration of law in relation to internal revenue."

[4] *See* Fribourg Navigation Co. v. Comm'r, 383 U.S. 272 (1966).

[5] *See* Dixon v. United States, 381 U.S. 71, 75 (1965).

> to the benefit of any private shareholder or individual. . . ."

It is well established that the term "charitable" is used in section 501(c)(3) in its generally accepted legal sense, is not limited by the separate enumeration of other tax exempt purposes in that section and must be construed within the broad outlines of "charity" as developed by judicial decisions. Treas. Reg. §1.501(c)(3)-1(d)(2) (1959).[6] This Regulation reflects the long-standing recognition of the fact that the interpretation of the term "charitable" for purposes of the charity provisions of the Code is governed by the general law of charities and charitable trusts.[7] Both the Internal Revenue Service (hereinafter "IRS") and the courts have exhibited a continuing commitment to this rule.[8] A recent IRS expression of this

[6] The Regulation states, in part:

> "The term 'charitable' is used in section 501(c)(3) in its generally accepted legal sense and is, therefore, not to be construed as limited by the separate enumeration in section 501(c)(3) of other tax-exempt purposes which may fall within the broad outlines of 'charity' as developed by judicial decisions."

Treas. Reg. §1.501(c)(3)-1(d)(2) was promulgated in its present form in 1959 as T.D. 6391, 24 Fed. Reg. 5217 (1959) and has remained in effect without change through numerous amendments to the exempt organization provisions of the Code, particularly the extensive enactments relating to charities in the Tax Reform Act of 1969, Pub. L. No. 91-172, 83 Stat. 487, and thus may be deemed to have the tacit approval of Congress.

[7] *See, e.g.*, Pennsylvania Co. for Ins. v. Helvering, 66 F.2d 284, 286 (D.C. Cir. 1933); Girard Trust Co. v. Comm'r, 122 F.2d 108 (3d Cir. 1941); Samuel Friedland Found. v. United States, 144 F. Supp. 74, 81-82 (D. N.J. 1956).

[8] For example, in holding a bequest for the erection of a community auditorium to be charitable and thus deductible under section 403(a)(3) of the Revenue Act of 1918, Sol. Op. 159, III-1 CUM. BULL. 480 (1924), states:

> "It becomes necessary to determine just what was contemplated by Congress in the use of the word 'charitable'. There being no statutory definition of the word, it must be construed in accordance with its well understood common law

(Footnote continued on following page)

principle is found in *Rev. Rul. 67-325*, 1967-2 CUM. BULL. 113:

> "The favored treatment of charitable organizations for Federal tax purposes in the income, estate and gift tax legislation enacted in the current century has not provided a comprehensive definition of charitable purposes in the various statutory provisions that have been enacted. *It is clear for this and other reasons that those statutory provisions* do not reflect any novel or specialized tax concept of charitable purposes, and that the income, estate, and gift tax provisions of the Code here in question *should be interpreted as favoring only those purposes which are recognized as charitable in the generally accepted legal sense.*" (Emphasis supplied.)

The strongest judicial recognition of the importance of the general law of charities and charitable trusts in interpreting the charitable exemption is stated in *Green v. Connally*, 330 F. Supp. 1150, 1157 (D. D.C. 1971), *aff'd per curiam sub. nom. Coit v. Green*, 404 U.S. 997 (1971):

> "[C]learly, the term 'charitable' is used 'in its generally accepted legal sense,' Treas. Reg. §1.501(c)(3)-1(d)(2), and not in a street or popular sense (such as, e.g., benevolence to the poor and suffering) . . . Thus 'strong analogy' can be derived from the general common law of charitable trusts, at least for close interpretative questions."[9]

(Continued from previous page)

meaning. In *Rice v. Minnesota & Northwestern Railroad Company* (1 Black, 358) the Supreme Court of the United States said: 'In the construction of the laws of Congress the rules of common law furnish the true guide.'"

See also Swearingen v. United States, 161 U.S. 446 (1895); United States v. Wong Kim Ark., 169 U.S. 649 (1898); 2A D. SANDS, STATUTES AND STATUTORY CONSTRUCTION §50.04 (4th ed. 1973).

[9] The Court of Appeals for the District of Columbia, in interpreting the phrase "organized and operated exclusively for

(Footnote continued on following page)

B. Rev. Rul. 69-545 Is Based Upon the Established Legal Doctrine That Promotion of Health for the Benefit of the Community Is, in the Absence of Private Benefit, a Charitable Purpose Within the Meaning of Section 501(c)(3).

Prior to the publication of *Rev. Rul. 69-545*, the criteria for tax exemption of nonprofit hospitals were generally set forth in *Rev. Rul. 56-185*. Although this Ruling required consideration of various factors in order to determine a hospital's charitable status, particular emphasis had been placed on the requirement that "[i]t must be operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay." The satisfaction of this requirement was generally interpreted to require that a hospital must provide some undefined percentage of services to indigent patients without charge or at reduced rates.

Rev. Rul. 69-545 was issued to provide alternative standards for determining the qualification of nonprofit hospitals for tax exemption under section 501(c)(3).[10]

(Continued from previous page)

religious, charitable, scientific, literary, or educational purposes" for purposes of section 1(b)(7) of the District of Columbia Unemployment Compensation Act, found a Congressional intent "to apply the exemption to those organizations commonly designated charitable in the law of trusts. Consequently, we may properly draw analogy from the trust cases." Int'l Reform Fed'n v. Dist. Unemployment Comp. Bd., 131 F.2d 337, 339 (D.C. Cir.), *cert. denied*, 317 U.S. 693 (1942).

[10] As stated by the Court of Appeals below:

> "It is important to note also that Revenue Ruling 69-545 rather than over-ruling Revenue Ruling 56-185 simply provides an alternative method whereby a nonprofit hospital can qualify as a tax exempt charitable organization." Pl. Br. for Certiorari App. C. at 27a.

The rationale of the Ruling, as set forth in its text,[11] is that the promotion of health is a charitable purpose in the generally accepted legal sense. A nonprofit hospital, which is free of private benefit and which is engaged in the promotion of health in a manner beneficial to the community, is therefore a charitable organization within the meaning of section 501(c) (3). As evidence that a nonprofit hospital is serving a broad enough class to benefit the community, *Rev. Rul. 69-545* requires an exempt hospital to (a) operate an emergency room open to all persons and (b) provide hospital care for all those persons in the community able to pay the cost thereof, directly or through third party reimbursement.

The Ruling also provides that further evidence of benefit to the community can be established by other factors, such as the use of surplus funds to improve the quality of patient care, expansion of facilities and advancement of medical training, education and research programs; broad public control; and maintenance of an open medical staff.[12]

[11] Rev. Rul. 69-545, 1969-2 CUM. BULL. 117, 118 states:

"In the general law of charity, the promotion of health is considered to be a charitable purpose. *Restatement (Second), Trusts*, sec. 368 and sec. 372; IV *Scott on Trusts* (3d ed. 1967), sec. 368 and sec. 372. A nonprofit organization whose purpose and activity are providing hospital care is promoting health and may, therefore, qualify as organized and operated in furtherance of a charitable purpose. . . .

. . . .

"The promotion of health, like the relief of poverty and the advancement of education and religion, is one of the purposes in the general law of charity that is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community, such as indigent members of the community, provided that the class is not so small that its relief is not of benefit to the community. *Restatement (Second), Trusts*, sec. 368, comment (b) and sec. 372, comments (b) and (c); IV *Scott on Trusts* (3d ed. 1967), sec. 368 and sec. 372.2."

[12] "These factors indicate that the use and control of Hospital *A* are for the benefit of the public and that no part of the income of the organization is inuring to the benefit of any private individual nor is any private interest being served." *Id.*

Finally, *Rev. Rul. 69-545* removes as an indispensible criterion to qualification under section 501(c)(3) the requirement of rendering care for patients without charge or at rates below cost.

Thus, as stated in *Rev. Rul. 69-545*, the basis for the alternative standards set forth therein for tax exemption of nonprofit hospitals is that promotion of health in a manner which is beneficial to the community and free of any private benefit or profit is a charitable purpose. If this fundamental proposition is consistent with the general law of charities and charitable trusts, and thus the charitable provisions of section 501(c)(3), the decision of the Court of Appeals below must be affirmed.

C. The Promotion of Health Is a Charitable Purpose.

Any discussion of charitable purposes must begin with the fundamental principle that "[a] design to achieve objects beneficial to the community is common to all charitable purposes." *In re Tollinger's Est.*, 349 Pa. 393, 397, 37 A.2d 500, 502 (1944); *In re United Presbyterian Homes*, 428 Pa. 145, 148, 236 A.2d 776, 779 (1968).[13] For this reason, the term "charitable" has traditionally been defined broadly enough to encompass all of those activities which promote the well-being of man.[14]

Since the enactment of the Statute of Elizabeth (aka the Statute of Charitable Uses), Stat. 43 Eliz. 1, c.4 (1601),

[13] In *Green v. Connally*, 330 F. Supp. 1150, 1158 (D. D.C. 1971) the court said:

"Underlying the law of charitable trusts is the conception, both in definition and in requirement, that a charitable trust is one formed to serve the general welfare and be beneficial to the community."

See also A. SCOTT, THE LAW OF TRUSTS §374 (3d ed. 1967); G. BOGERT, THE LAW OF TRUSTS AND TRUSTEES §363 (2d ed. 1964).

[14] In *Ould v. Washington Hosp.*, 95 U.S. 303, 311 (1877) the Court said:

(Footnote continued on following page)

certain specific purposes have come to be widely regarded in the law as charitable. Nevertheless, because of the difficulty of enumerating every purpose in the ever expanding catalogue of charitable purposes, great weight has been given to Lord Macnaghten's definition in *Commissioners v. Pemsel*, [1891] A.C. 531, 583, 3 Tax Cas. 53, 96, which enumerates three basic charitable purposes and a fourth charitable category of other purposes beneficial to the community.

Referring to this classic statement, Mr. Justice White, concurring in *Evans v. Newton*, 382 U.S. 296, 307-08 (1966), observed:

> "Lord Macnaghten established a classification of charitable trusts that, with some modifications, has since prevailed: ' "Charity" ' in its legal sense comprises four principal divisions: trusts for the relief of poverty; trusts for the advancement of education; trusts for the advancement of religion; and trusts for other purposes beneficial to the community, not falling under any of the preceding heads."[15]

As far back as the Statute of Elizabeth's classification of the "relief of aged, impotent, and poor people" as a charitable purpose, it has also been recognized that, as a matter of law, the relief of the suffering and distress of sick and

---

(Continued from previous page)

> "A charitable use, where neither law nor public policy forbids, may be applied to almost any thing that tends to promote the well-doing and well-being of social man."

A similar broad treatment is applied to the nature of charitable purposes in RESTATEMENT (SECOND) OF TRUSTS §368 and *Comment (b)* (1959):

> "A purpose is charitable if its accomplishment is of such social value to the community as to justify permitting the property to be devoted to the purpose in perpetuity."

[15] *See also* Int'l Reform Fed'n v. Dist. Unemployment Comp. Bd., 131 F.2d 337, 339 (D.C. CIR. 1942); RESTATEMENT (SECOND) OF TRUSTS §368 (1959).

aged persons is a charitable purpose.[16]

Although relief of the distress of the sick and aged has often been subsumed under Lord Macnaghten's fourth category of purposes beneficial to the community, it has more frequently been spun off from this category and separately treated as a fifth heading of charitable purposes in English and American law.[17] It is now "well settled that the promotion of health is a charitable purpose." A. SCOTT, THE LAW OF TRUSTS §368, at 2853 (3d ed. 1967); *id.* §372, at 2893 and cases cited at 2894-97; G. BOGERT, THE LAW OF TRUSTS AND TRUSTEES §374, at 107 (2d ed. 1964).[18]

---

[16] Another classic and widely cited definition of charity is Justice Gray's in *Jackson v. Phillips*, 96 Mass. (14 Allen) 539,556 (1867):

> "A charity is a gift to be applied consistently with existing laws, for the benefit of an indefinite number of persons, either by bringing their minds or hearts under the influence of education or religion, *by relieving their bodies from disease, suffering or constraint*, by assisting them to establish themselves in life, or by erecting or maintaining public buildings or works, or otherwise lessening the burdens of Government." (Emphasis supplied.)

[17] "[T]he relief of distress, that is . . . 'the relief of any form of necessity, destitution or helplessness which excites the compassion or sympathy of men', could with advantage be moved out of the fourth head. It is charitable not because of the immediate benefit to the public but for reasons of human sympathy *akin to those which make relief of poverty a charitable object* . . . The relief of distress could, if desired, be treated as a separate fifth head of charity or it might well be combined with relief of poverty, which is in truth one among many forms of distress." Brunyate, *The Legal Definition of Charity*, 61 L. Q. REV. 268, 281 (1945) (emphasis supplied).

[18] "[T]he promotion of health is a valid charitable purpose in all American jurisdictions." E. FISCH, D. FREED AND E. SCHACHTER, CHARITIES AND CHARITABLE FOUNDATIONS §322, at 275 (1974); *see also id.* §322, at 275 n.18.

RESTATEMENT (SECOND) OF TRUSTS §368 (1959):

"Charitable purposes include

"(a) the relief of poverty;

"(b) the advancement of education;

(Footnote continued on following page)

The true significance of the treatment of promotion of health as a separate charitable purpose in the law of charity is that it forms an independent basis for the underlying principle of *Rev. Rul. 69-545* that a nonprofit health organization, free of the taint of private benefit or profit, qualifies as a charitable organization without regard to providing free care for the poor.[19]

(Continued from previous page)

"(c) the advancement of religion;
"(d) *the promotion of health;*
"(e) governmental or municipal purposes;
"(f) other purposes the accomplishment of which is beneficial to the community."

(Emphasis supplied.)

"[T]he care of the sick and the suffering is generally recognized as a charitable purpose." Duncan v. Steeper, 17 Wis. 2d 226, 116 N.W.2d 154, 158 (1962); *see* Sacks, *The Role of Philanthropy: An Institutional View*, 46 VA. L. REV. 516, 518 (1960).

[19] In recognition of the legal principle that the promotion of health is a charitable purpose, the IRS has issued a series of revenue ruling recognizing the tax-exempt status of organizations under section 501(c)(3) that are engaged in performing various functions relieving the distress of the sick and aged. If the lower court decision is reversed, some of the organizations whose exempt status would have to be reconsidered by the IRS, and perhaps denied. *See, e.g.*, Rev. Rul. 70-590, 1970-2 CUM. BULL. 116 (operating a clinic to aid drug victims); Rul. 68-73, 1968-1 CUM. BULL. 251 (organization ministering to the nonmedical needs of patients in a proprietary hospital); Rev. Rul. 55-656, 1955-2 CUM. BULL. 262 (a community supported nurse's registry); Rev. Rul. 66-323, 1966-2 CUM. BULL. 216 (blood bank); Rev. Rul. 69-525, 1969-2 CUM. BULL. 115 (organization conducting research in heart disease); Rev. Rul. 65-298, 1965-2 CUM. BULL. 163 (organization carrying on research on diseases of the human body); Rev. Rul. 73-569, 1973-2 CUM. BULL. 178 (an organization providing free abortion counseling); Rev. Rul. 69-174, 1969-1 CUM. BULL. 149 (organization providing free rescue and emergency services); Rev. Rul. 72-209, 1972-1 CUM. BULL. 148 (organization providing home health care); Rev. Rul. 73-313, 1973-2 CUM. BULL. 174 (organization formed to attract a physician to an isolated rural community); Rev. Rul. 72-124, 1972-1 CUM. BULL. 145 (homes for the aged); Rev. Rul. 75-198, 1975-22 INT. REV. BULL. 9 (service center for senior citizens); Rev. Rul. 75-197, 1975-22 INT. REV. BULL. 8 (organization operating a medical retrieval system for transplanting body organs).

D. The Relief of Poverty Is Not a Necessary Ingredient for Charitable Exemption.

Although the gravamen of the substantive dispute between the parties is whether the relief of poverty is a necessary ingredient of charitable purposes, this issue has long been settled.[20] The promotion of health is a charitable purpose because the alleviation of the suffering and distress of the sick and aged is, per se, a purpose beneficial to the community. Therefore, the relief of poverty is not necessary for this type of charity.[21]

The principle that charity is not limited to the relief of poverty was part of the common law during the period of the enactment of the first charitable exemption in the 1909 Act. Act of Aug. 5, 1909, ch. 6, §38, 36 Stat. 11, 113.[22] One widely quoted expression of this long-standing principle is that:

> "Since the enactment of the Statute of Charitable Uses during the reign of Elizabeth, aid to the aged and in-

---

[20] "Although the relief of the poor, or a benefit to them is, in the popular sense, a necessary ingredient in charity, this is not so in view of the law." Paschal v. Acklin, 27 Tex. 173, 199 (1863).

[21] The courts have not limited their compassion to the poor, but also include as objects of charity other classes of distressed persons, such as the sick and aged. Although relief of poverty is a necessary ingredient for charities engaged exclusively in alleviating the needs of the poor, the same is not true of charities relieving other forms of distress. This principle was restated by Professor Bogert as follows:

> "A trust to furnish the necessities of life to persons who are financially able to provide for themselves is not charity of the type under consideration. There is no social benefit in relieving members of the public from the burden of supporting themselves or in providing luxuries for them. If the group possesses certain disabilities such as age, sickness or physical handicaps, a trust to furnish benefits to its members may qualify as a charity of another type, regardless of the financial status of its personnel." G. BOGERT, THE LAW OF TRUSTS AND TRUSTEES §373, at 105 (2d. ed. 1964) (footnotes omitted).

[22] H. BLACK, A TREATISE ON THE LAW OF INCOME TAXATION 404 (2d ed. 1915):

(Footnote continued on following page)

> firm has been recognized as charitable . . . . Relief of poverty is not a condition of charitable assistance. If the benefit conferred has a sufficiently widespread social value, a charitable purpose exists. Restat. Trusts, Sec. 368, 374. *People v. Cogswell,* 113 Cal. 129, 45 P. 270, 35 L.R.A. 269; *Collier v. Lindley,* 203 Cal. 641, 266 P. 526; 16 Cal. L. Rev. 478." *In re Henderson's Est.*, 17 Cal. 2d 853, 112 P.2d 605, 607 (1941).[23]

Similarly, Professor Scott has observed that "[a] trust for the promotion of health, however, is none the less charitable, although the benefits are not limited to the poor."[24]

The recognition in American law that charity is not limited to the relief of poverty has developed from the interpretation of the charitable purposes enumerated in the Statute of Elizabeth,[25] the first of which is "the relief of aged, impotent, and poor people."[26] English jurists were confronted with a question similar to that raised by plaintiffs, namely, "whether age per se or impotence [i.e., sickness] per se without any element of poverty can be re-

---

(Continued from previous page)

"[I]t is the general rule in the construction of exemptions from taxation that the word 'charity' is not to be restricted to the relief of the sick or poor, but extends to any form of philanthropic endeavor or public benevolence."

See also 14 C.J.S., *Charities* §12, at 439 (1939); Gerke v. Purcell, 25 Ohio St. 229 (1874).

[23] *Accord,* Commun. Mem'l Hosp. v. City of Moberly, 422 S.W.2d 290 (Mo. 1967); *In re* Rust's Est., 168 Wash. 344, 12 P.2d 396 (1932).

[24] A. Scott, The Law of Trusts §372, at 2895 (3d ed. 1967); *see also* Green v. Connally, 330 F. Supp. 1150, 1157 (D. D.C. 1971).

[25] Referring to American exemption statutes, Professor Zollmann states:

"It can admit of no doubt that the words 'charitable purposes' must be construed according to the standards set by the statute of Elizabeth and its interpretations." C. Zollmann, American Law of Charities 470 (1924); *see also* IV A. Scott, The Law of Trusts §348.3, at 2787.

[26] The term "impotent," as used in the Preamble of the Statute of Elizabeth, has been interpreted to mean sick persons. *Charitable Purposes,* 106 Sol. J. 969 (1969).

garded as good charitable objects."[27] In dispute was whether the phrase "relief of aged, impotent and poor people" should be read in the *disjunctive,* permitting charitable trusts to operate for the benefit of sick or aged people without reference to their financial condition, or in the *conjunctive,* thereby limiting charitable trusts to those operating for the benefit of the sick poor or the aged poor.[28]

The conclusion reached under English law was that "[t]he words 'aged, impotent and poor' should be read disjunctively."[29] For example, in 1954, Chancery held a bequest to blind children to be charitable, although there was no requirement of poverty, because the word "impotent," as used in the Preamble to the Statute of Elizabeth should be read disjunctively. *In re Lewis* (1954), 3 All E. R. 257.[30]

The disjunctive reading of the phrase "relief of aged, impotent and poor people" is now generally accepted as the

---

[27] Atiyah, *Public Benefit of Charities,* 21 Mod. L. Rev. 138 (1958).

[28] A similar issue is raised in Pl. Br. at 17 n.12 with respect to Treas. Reg. §1.501(c)(3)-1(d)(2) which defines charity to include "Relief of the poor *and* distressed or of the underprivileged." (Emphasis supplied.)

[29] *In re* Glyn, [1950] 2 All E.R. 1150. *Accord, In re* Wall, [1889] 42 Ch. 510; *In re* Lucas, [1922] 2 Ch. D. 52; *In re* Bradbury, [1951] 1 T.L.R. 130 (Ch. D.); *In re* Robinson, [1951] Ch. 198; *see also In re* Roadley, [1930] 1 Ch.D. 524, 527: "A trust to provide out of the income for the expenses and maintenance of patients in a hospital is a trust for the relief of impotent people and therefore, in my judgment, a good charitable trust."

[30] Commenting on *In re Lewis,* one authority noted:

"This decision thus takes a further step in establishing that there are three separate types of charity under this head: (1) Trusts for the relief of poverty, (2) Trusts for the relief of the aged, and (3) Trusts for the relief of the impotent." Atiyah, *The Aged, Impotent and Poor,* 18 Mod. L. Rev. 76 (1955).

Accord, In re Estlin, 72 L.J. (Ch.D.) 687; *In re* Chaplin, [1932] 1 Ch.D. 115; *In re* James, [1932] 2 Ch. 25; *In re* Frasure, [1883] 22 Ch.D. 827; *In re* Elliott, [1910] 102 L.T.R. (n.s.) 528.

law of England.[31] Even the prestigous Nathan report, in reviewing the current status of the Law of Charity in England states:

> "One or two doubts were expressed. It was suggested, for example, that it was not wholly clear that the relief of sickness or of the infirmities of aged is a charitable object unless the conditions requiring relief is accompanied by poverty. *We believe these doubts to be unfounded.*" COMMITTEE ON LAW AND PRACTICE, REPORT RELATING TO CHARITABLE TRUSTS CMD. NO. 8710, at 33 (1952) (emphasis supplied).

Similar doubts have been expressed in American law, but have been dismissed either as a too narrow and restricted a view of charity[32] or simply as a mistaken view.[33] For example, in referring to the argument that a nonprofit home for aged was required to extend free services to at least some of its residents, the Supreme Court of Wisconsin stated:

---

[31] *E.g.*, 5 HALSBURY'S LAWS OF ENGLAND §514 (4th ed. 1974); "The relief of 'aged, impotent and poor people' is charitable and the words are to be read disjunctively, so that the relief of aged people who are not also poor comes within them, and the relief of impotence, without any element of poverty is a charitable purpose."

Accord, In re Hiller, [1944] 1 All E.R. 480; Brunyate, *The Legal Definition of Charity*, 61 L. Q. Rev. 268 (1945).

[32] "Counsel for the Board insist that, in order to be classified as a charitable corporation, it is necessary that appellant show that its principal objectives are to provide for the poor, the sick, and the needy, but we think this is too narrow and restricted a formula." Int'l Reform Fed'n v. Dist. Unemployment Comp. Bd., 131 F.2d 337, 339 (D.C. Cir. 1942).

[33] Duncan v. Steeper, 17 Wis. 2d 226, 116 N.W.2d 154, 158 (1962):

> "It is apparent that respondents harbor the *mistaken view* that an institution cannot be a charitable hospital unless it extends direct charity to at least some of its patients in the form of free service, or charges less than the cost of its services. This view was eloquently refuted by the Massachusetts court in the recent case of Barrett v. Brooks

(Footnote continued on following page)

> "This is a 'mistaken view' whether applied to benevolent retired homes for the aged or to charitable hospitals. If the legislature had intended that a benevolent association must provide free admission or free services to all or some of the residents in its retirement home, it is to be expected that it would have so provided." *Milwaukee Protestant Home v. City of Milwaukee*, 41 Wis. 2d 284, 164 N.W.2d 289, 297 (1969) (footnote omitted).

Thus, the law of charity and charitable trusts does not support plaintiffs' assertion that "[s]ervice to persons unable to pay is the *sine qua non* for charitable hospitals."[34] Rather, the law is that the relief of poverty is not a required condition for charitable status of nonprofit hospitals.

E. A Nonprofit Hospital, Free of the Taint of Private Benefit or Profit, Is Charitable.

Since the promotion of health is a charitable purpose, and relief of the poor is not requisite to charitable status, numerous legal authorities have concluded that "[h]ospitals operated as nonprofit institutions are universally classed as charitable institutions. 15 AM. JUR. 2d, *Charities*, s. 79, p. 85, s. 148, p. 156; 14 C.J.S. *Charities* §2 e, p. 422; §16, p. 448; 84 C.J.S. *Taxation* §297, p. 617." *Evangelical Lutheran Good Samaritan Soc. v. County of Gage*,

---

(Continued from previous page)

Hospital, Inc., [338 Mass. 754, 759, 157 N.E. 2d 638, 641 (1959)]:

> 'The defendant's charter does not contain any such word as "indigent." That is not necessary. "Charity in the legal sense 'is not confined to mere almsgiving or the relief of poverty and distress, but has a wider signification, which embraces the improvement and promotion of the happiness of man.' . . . New England Sanitarium v. Inhabitants of Stoneham, 205 Mass., 335, 342, 91 N.E. 385, [citation omitted]." (Emphasis supplied.)

[34] Pl. Br. at 17.

181 Neb. 831, 151 N.W.2d 446, 449 (1967).[35]

One court summarized its analysis of whether a nonprofit hospital is charitable as follows:

> "Is there a definite test which can be given? If the purpose of the institution is one which is recognized in law as charitable and if it is not maintained for the private gain, profit, or advantage of its organizers, officers, or owners, directly or indirectly, we think the institution is properly characterized as a charitable one, notwithstanding the fact that it charges for most, if not all, of the services which it may render, so long as its receipts are devoted to the necessary maintenance of the institution and the carrying out of the purpose for which it was organized. . . .

[35] Most other jurisdictions have recognized this principle as well. For example:

> "The legal interpretation of the phrase 'not for profit, but exclusively as charities', is not controlled by free service to the indigent or poor. Nonprofit hospitals which are devoted to the care of the sick, which aid in maintaining public health, and contribute to the advancement of medical science, are and should be regarded as charities." City of Richmond v. Richmond Mem'l Hosp., 202 Va. 86, 116 S.E.2d 79, 84 (1960).

> "[The Swedish Hospital] is a charitable corporation because all of its earnings are devoted to providing care for the sick and afflicted or in the construction of additions and improvements to enlarge its usefulness." Weiss v. Swedish Hosp., 16 Wash. 2d 446, 133 P.2d 978, 980 (1943).

> "Hospitals which are devoted to the care of the sick and injured, which aid in maintaining public health and which make valuable contributions to the advancement of medical science are rightly regarded as benevolent and charitable. A hospital association not conducted for profit which devotes all of its funds exclusively to the maintenance of the institution is a public charity and this is so irrespective of whether patients are required to pay for the services rendered. Butterworth v. Keeler, [citation omitted]; Matter of Mendelsohn, 262 App. Div. 605, 610, 31 N.Y.S.2d 435, 440; Jewish Mental Health Soc. v. Village of Hastings-on-Hudson, 255 App.; Div. 77, 5 N.Y.S. 2d 567, affirmed, 279 N.Y.S.2d 764, 18 N.E.2d 857." People *ex rel.* Doctors Hosp., Inc. v. Sexton, 267 App. 736, 48 N.Y.S.2d 201 (1944), *aff'd mem.*, 295 N.Y. 553, 64 N.E.2d 273 (1945).

> . . . .
>
> "'[T]he test of whether an enterprise is charitable is whether it exists to carry out a purpose recognized in law as charitable, or whether it is maintained for gain, profit, or private advantage.'" *So. Methodist Hosp. and Sanitarium v. Wilson*, 51 Ariz. 424, 77 P.2d 458, 462-63 (1938).[36]

Since promotion of health is a charitable purpose, a nonprofit hospital will satisfy these tests unless operated for private gain.

Plaintiffs assert that "[n]onprofit hospitals which do not provide free care are no more charitable than the for-profit hospitals with which they compete. Nonprofit status is not, of course, sufficient in itself to confer charitable status." Pl. Br. at 16 (footnote omitted). Plaintiffs make two fundamental errors in this assertion. First, they ignore the fact that the promotion of health is regarded under the law of charity as a charitable purpose. Second, they ignore the fact that a nonprofit organization operating in furtherance of a charitable purpose is distinguishable from a commercial enterprise by reason of the absence of private profit.

The law, however, has not ignored this distinction. As Mr. Justice Cardozo (then Judge) stated in *Butterworth v. Keeler*, 219 N.Y. 446, 114 N.E. 803, 804 (1916):

> "What controls is not the receipt of income, but its purpose. Income added to the endowment helps to make it possible for the work to go on. It is only

[36] In holding a nonprofit hospital to be a public charity, the court in *McDonald v. Mass. Gen'l Hosp.*, 120 Mass. 432, 21 Am. Rep. 529 (1876), noted that

> "[i]ts affairs are conducted for a great public purpose, that of administering to the comfort of the sick, without any expectation on the part of those immediately interested in the corporation, of receiving any compensation which will inure to their own benefit, and without any right to receive such compensation. This establishes its character as a public charity. Jackson v. Phillips, 14 Allen 539."

when income may be applied to the profit of the founders that business has a beginning and charity an end."

The Court recognized the same principle in *Trinadad v. Sagrada Orden*, 263 U.S. 578, 581 (1924) where it stated:

"[T]he [charitable] exemption is made in recognition of the benefit which the public derives from corporate activities of the class named, and is intended to aid them when not conducted for private gain."

More recently, the Supreme Court of Wisconsin has undertaken to distinguish charitable activities from proprietary business enterprises:

"What distinguishes the benevolent undertaking, *operated not for profit*, from the private operation, operated as a business enterprise? Increasingly, this question is coming to the courts for the interpretation and application of existing statutes to retirement homes for the aged. Most state courts appear to be answering that such providing of paid-for services to aged persons of modest resources and income is an act of benevolence or charity. Such courts adopt what this court, with approval has called '. . . broad definitions of "charitable" ' institutions which do not embody the idea of giving something away free." *Milwaukee Protestant Home v. City of Milwaukee*, 41 Wis. 2d 284, 164 N.W.2d 289, 292 (1969) (emphasis supplied).[37]

[37] This rationale, as applied to hospitals, is found in *Duncan v. Steeper*, 17 Wis. 2d 226, 116 N.W.2d 154, 158 (1962):

"[T]he test of whether an enterprise, such as a hospital, is charitable is its purpose, and that, if its purpose is to heal the sick and relieve the suffering without hope or purpose of gain from its operation, it is charitable. . . .

. . . .

[T]he gain or profit which destroys the charitable character of a corporation is that which inures to the benefit of its member and is not affected by the fact that the corporation's income may exceed its operating expenses."

(Footnote continued on following page)

Rev. Rul. 69-545 may be more restrictive than the proposition that a nonprofit hospital is per se charitable because the ruling requires further evidence of community benefit, i.e., an open emergency room and the provisions of services to Medicare and Medicaid patients. However, the fact that the law recognizes that a nonprofit hospital, free of private benefit or profit, is charitable without regard to the quantum of free care provided, offers compelling support for the validity of *Rev. Rul. 69-545*. In view of the principles set forth in the decisions discussed above, the Commissioner cannot be said to have exceeded his authority in enunciating the criteria for charitable hospitals set forth in *Rev. Rul. 69-545*.

F. Rev. Rul. 69-545 Is Consistent with the Rationale for Tax Exemption Under Section 501(c)(3).

Although, as indicated above, the criteria of *Rev. Rul. 69-545* are consistent with the legal requirements for exemption of "charitable" hospitals under section 501(c)(3), plaintiffs attempt to refute this position by shifting ground from the question of what are charitable purposes to the question of what is the basis for exemption of organizations operating in the furtherance of charitable purposes.

They assert that tax exemption of charitable organizations is "conferred on the theory that the charitable organizations are performing functions which would other-

(Continued from previous page)

Accord, Riverview Hosp. v. City of Tomahawk, 243 Wis. 581, 584, 11 N.W.2d 188, 189 (1943), stating with respect to whether a hospital is exempt from property tax as a charitable institution:

"The test is its origin and the objects of its organizers, its complete dedication to charitable purposes and absolute divorce from gain to those controlling ownership." *Accord*, Assoc. Hosp. Services, Inc. v. City of Milwaukee, 13 Wis. 2d 447, 109 N.W.2d 271 (1961); Rueda v. Union Pac. Ry., 180 Ore. 133, 169, 175 P.2d 778, 793 (1946).

wise need to be performed by government and are, therefore, lessening the burdens of government." Plaintiffs go on to conclude that nonprofit hospitals which do not provide free or below cost care are not lessening the burdens of government and are therefore not entitled to tax exemption. Pl. Br. at 15-16.

Plaintiffs' statement is inaccurate in two respects: first, the concept of "lessening of burdens of government" is a rationale for tax exemption which does not represent the prevailing legal view, and, second, in any event, a tax exempt organization may lessen the burdens of government by carrying on charitable activities other than those which relieve poverty.

Lessening of the burdens of government is but one of two rationale for the granting of tax exemptions.[38] The other rationale is that tax exemption is granted to encourage humanitarian and other socially desirable activities

---

[38] Referring to these two rationale for granting tax exemption, one author has commented that:

> "One suggested motive for [tax] exemptions is the desire to assist organizations doing the state's work since the state will not lose and will gain if loss in revenue is exceeded by savings resulting from private performance of functions that would otherwise be the state's responsibility. A more generous theory which has been imputed to the legislature is that the state should encourage not only functions easing the state's burden, but all activities devoted to humanitarian goals." Note, *Exemption of Educational, Philanthropic and Religious Institutions from State Real Property Taxes*, 64 HARV. L. REV. 288, 288-89 (1950) (footnotes omitted).

Accord: "The decisions recognizing tax exemption are rested principally upon the conclusion that people in later years have special care and residential requirements, the alleviation of which is of social value; and that exemption should be allowed where such needs are being met by institutions not organized or operated for private profit." Hilltop Village, Inc. v. Kirtland Independent School District, 426 S.W.2d 943, 947-48 (Tex. 1968). *See also* Note, *Humanitarian Approach to Taxation of Homes for the Aged*, 4 WILLAMETTE L. J. 504 (1967).

by the private sector,[39] and this rationale is clearly the prevailing basis for tax exemption.[40] A classic statement of the basis for the humanitarian approach was made by Chief Justice Marshall in *Dartmouth College v. Woodward*, 17 U.S. (4 Wheat.) 518, 637 (1819). Referring to Dartmouth College, he stated that "[t]he objects for which a corporation is created are universally such as the government wishes to promote. They are deemed beneficial to the country; and this benefit constitutes consideration, and, in most cases, the sole consideration of the grant."

For example, the longstanding exemption of churches from Federal income and real property taxation is not based on the "public burden" rationale for tax exemption. Churches have never been exempt because they relieve the state of an economic burden.[41] "Consequently, courts

---

[39] Note, *Exemption of Educational, Philanthropic and Religious Institutions from State Real Property Taxes*, 64 HARV. L. REV. 288, 288-89 (1950). *Accord*, Y.M.C.A. v. Los Angeles County, 35 Cal. 2d 760, 221 P.2d 47, 52 (1950).

[40] The jurisdictions which recognize that promotion of health (or relief of the distress of the sick or aged) is a charitable purpose have adopted the humanitarian approach. *See* Sec. I, B-D *supra*. In addition, most jurisdictions have indicated approval of this rationale in their exemption of homes for the aged. R. BROMBERG, *Charity and Change: Current Problems of Tax Exempt Organizations in Perspective*, TAX PROBLEMS OF CHARITIES 1970, at 249 (Webster & Lehrfeld eds. 1970) and the cases at 265 n. 41. Note, *Humanitarian Approach to Taxation of Homes for the Aged*, 4 WILLAMETTE L. J. 504, 510 (1967). *See also* Bromberg, *Non-profit Homes for the Aged: An Analysis of Their Current Tax Exempt Status*, 38 J. TAX. 54 (1973).

[41] Walz v. Tax Comm'n, 397 U.S. 664, 675 (1970). Although the issue before the Court was whether the state tax exemption of churches was a violation of the religion clauses of the First Amendment, many of the statements in that decision bear upon the issue now before the Court and provide support for the humanitarian approach under consideration. In the majority opinion, the Court stated that New York State has "granted exemption to all houses of religious worship within a broad class of property owned by nonprofit, quasi-public corporations which include hospitals, libraries, playgrounds, scientific, professional,

(Footnote continued on following page)

are compelled to justify exemption of property used for religious purposes on the basis of a separate rationale often referred to as the 'humanitarian doctrine' of tax exemption."[42]

Tax exemptions and charitable deductions relating to foreign charities and charitable activities also illustrate the pervading "humanitarian" rationale behind tax exemption. Domestic corporations may qualify for tax exemption even though all of their charitable activities are carried on abroad. *Rev. Rul. 71-460*, 1971-2 CUM. BULL. 231. Foreign charities can qualify for Federal income tax exemption even if organized and operated for charitable purposes outside the United States and can also receive

---

(Continued from previous page)

historical and patriotic groups. The State has an affirmative policy that considers these groups as beneficial and stabilizing influences in community life and finds this classification useful, desirable, and in the public interest." *Id.* at 680. Mr. Justice Brennan, concurring, also considered the rationale for tax exemption, encompassing both the lessening of burdens of government theory suggested above (see discussion footnote 38 *supra*) and the classic humanitarian approach to tax exemption of charitable institutions.

> "Government has two basic secular purposes for granting real property tax exemption to religious organizations. First, these organizations are exempt because they, among a range of other private, nonprofit organizations contribute to the well-being of the community in a variety of nonreligious ways, and thereby bear burdens that would otherwise have to be met by general taxation, or be left undone, to the detriment of the community . . . .
>
> . . . .
>
> "Second, government grants exemptions to religious organizations because they uniquely contribute to the pluralism of American society by their religious activities. Government may properly include religious institutions among the variety of private, non-profit groups that receive tax exemptions, for each group contributes to the diversity of association, viewpoint, and enterprise essential to a vigorous, pluralistic society." *Id.* at 687, 689.

[42] Note, *Humanitarian Approach to Taxation of Homes for the Aged*, 4 WILLAMETTE L. J. 504, 509 (1967).

grants from domestic private foundations. Treas. Reg. §1.509-2(a); Treas. Reg. §53.4945-5(a)(5); Treas. Reg. §53.4942(a)-3(a)(6); *Rev. Proc. 59-31*, 1959-2 CUM. BULL. 949. Furthermore, estate and gift tax provisions permit charitable gifts and bequests to be made directly to foreign charitable corporations. Code §2055(a); Code §2522(a). All these foreign activities, which still permit certain tax benefits, certainly do not lessen any burden of the United States government.[43]

Even assuming, arguendo, the applicability of the "public burden" rationale ascribed by plaintiffs, that rationale is not limited to the relief of poverty. If it were, there would be no explanation for the underlying rationale for tax exemption for the broad range of other types of charitable organizations which perform humanitarian and socially desirable functions, but which do not in any respect relieve poverty.[44]

---

[43] Plaintiffs attempt to buttress their "public burden" rationale by reference to legislative history which deals with the Code provision limiting the deductibility of individual contributions to domestic charities. Pl. Br. at 15 n. 9. Although the legislative history cited by plaintiffs does limit the charitable deductions for income tax purposes to domestic organizations, it does not limit the use of the funds received by such organizations to distribution within the United States. "If the recipient, however, is a domestic organization the fact that some portion of its funds is used in other countries for charitable and other purposes (such as missionary and educational purposes) will not affect the deductibility of the gift." H. R. REP. No. 1860, 75th Cong. 3d Sess. 19-20 (1938). The well established law governing contributions, gifts and bequests to or for the use of foreign charities and the tax-exempt status of such organizations, as discussed in the text, belies any attempt to extend plaintiffs' rationale to an all-inclusive statement of the basis for tax exemption of every charitable institution. See Eaton, *Charitable Foundations Making Grants Abroad*, 17 TAX L. REV. 41 (1961).

[44] The following are some of the organizations operating for the benefit of the community which are recognized by IRS as entitled to tax exemption as charitable organizations without reference to relief of poverty: Rev. Rul. 68-164, 1968-1 CUM. BULL. 252 (organization formed to promote safety in small boat con-

(Footnote continued on following page)

The legislative history under section 170 referred to by plaintiffs (Pl.Br. at 15 n. 9) does not even support plaintiffs' characterization.[45] Its language does not limit the "public burden" rationale to activities which relieve poverty. Rather it suggests that there are certain activities which might better be accomplished through private nonprofit organizations which receive contributions from the public than through direct governmental action.[46]

Thus under the "public burden" rationale, exemption is granted to encourage the private nonprofit sector to assume certain functions, not limited simply to the relief of poverty, which would otherwise have to be per-

---

(Continued from previous page)

struction and operation); Rev. Rul. 66-46, 1966-1 CUM. BULL. 133 (organization formed to promote public appreciation of group harmony singing); Rev. Rul. 65-271, 1965-2 CUM. BULL. 161 (organization created to develop and promote an appreciation of jazz music); Rev. Rul. 64-174, 1964-1 CUM. BULL. 183 (organization for establishment of repertory theatre); Rev. Rul. 67-292, 1967-2 CUM. BULL. 184 (organization developing sanctuary for wild birds and animals); Rev. Rul. 71-545, 1971-2 CUM. BULL. 235 (organization conducting international exposition); Rev. Rul. 65-191, 1965 CUM. BULL. 157 (organization operating community center); Rev. Rul. 70-640, 1970 CUM. BULL. 117 (organization providing personal marriage counseling services); Rev. Rul. 66-146, 1966-1 CUM. BULL. 136 (organization to encourage and recognize outstanding achievements and contributions of citizens); Rev. Rul. 64-275, 1964-2 CUM. BULL. 142 (organization formed to train candidates in sailboat racing techniques); Rev. Rul. 68-70, 1968-1 CUM. BULL. 194 (organization formed to advance equal job opportunities). See also revenue rulings based upon promotion of health as a charitable purpose cited under footnote 19 *supra*. For similar examples in Federal cases, *see* Bok v. McCaughn, 42 F.2d 616 (3d Cir. 1930); Broadway Theatre League v. United States, 293 F.Supp. 346 (D.C. Va. 1968).

[45] H. REP. No. 1860, 75th Cong., 3d Sess. 19-20 (1938).

[46] *E.g.*, "[T]he government exempts [charitable institutions] from paying taxes because if such enterprises did not exist the government would be required to use tax dollars to do the job the charitable enterprises are now doing." Friendsview Manor v. State Tax Comm'n, 247 Ore. 94, 420 P.2d 77, 82 (1966).

formed by government.[47] This is particularly true in the case of hospitals.

> "[C]onduct of a hospital has long been thought of as a legitimate function of government in preserving the health of the community. Additional weight has been given this proposition by the many cases which state that one of the bases of the tax exemption of charitable hospitals is that they relieve the state of the burden of providing hospital services and are, therefore, performing a quasi-governmental function."[48]

Without voluntary nonprofit hospitals, government would be forced directly to provide hospital care for our entire population. Indeed, one court has stated that "[e]liminate hospitals from our cities and our cities would vanish."[49] Therefore, under either the "public burden" rationale or the "humanitarian" rationale, tax exemption for voluntary nonprofit hospitals is justified without regard to the provision of free or below cost care.[50]

---

[47] ". . . the principal justification for tax benefits granted to these organizations and their donors should be that they relieved the government of what might otherwise be government functions which are better accomplished in this fashion than they would be through direct government expenditures of grants." Stone, *Federal Tax Support of Charities and Other Exempt Organizations: The Need for a National Policy*, 20 So. CAL. TAX. INST. 54 (1968).

[48] Horty, *Public Purpose Is The Key To Tax Exemption*, 106 MOD. HOSP. 60, 62 (March 1966).

[49] Ellis v. City of Grand Rapids, 257 F. Supp. 564, 572 (S.D. Mich. 1966):

> "When public, private and sectarian hospitals practice mercy toward men, they at the same time perform prime sectarian works and incomparable public services. Eliminate hospitals from our cities and our cities would vanish.
>
> "Promotion and improvement of our peoples health . . . is a fundamental obligation of governments, national, state and local . . . . The Congress of the United States and the state legislatures of the several states have in a multitude of ways established means to provide and care for the health of the people."

[50] "The general trend of authority in cases determining the

(Footnote continued on following page)

II. THE MODERN LEGAL DEFINITION OF A CHARITABLE HOSPITAL REFLECTS THE HISTORICAL EVOLUTION OF THE VOLUNTARY NONPROFIT HOSPITAL FROM ALMSHOUSE TO COMMUNITY HEALTH FACILITY.

The "mistaken view," espoused by plaintiffs, that a charitable hospital must provide free care to indigents is an anachronism which can be traced to the origins of our early hospitals and their subsequent development. Because this view nevertheless still persists in a minority of jurisdictions, the prevailing contemporary criteria for a charitable hospital expressed in *Rev. Rul. 69-545* can best be understood through an analysis of the historic development of the hospital as an institution and the response of the law of charity to changes in the functions and financing of that institution.

A. The Law of Charity Responds to the Changing Needs of Communities and the Institutions Which Serve Them.

The courts have consistently recognized that, in order to retain its vitality, "[t]he scope of charity and the standards under which it is administered are not frozen by the past, but keep pace with the times and the new conditions and wants of society."[51] Construing language identical to

(Continued from previous page)

charitable character of institutions for tax exemption veers away from the old concept that charity is confined to the 'free' care of the indigent, and toward the idea of charity as comprehending all humanitarian activities even though recipients may be able to pay at least in part for the benefits." Ann., *Receipt of Pay from Beneficiaries as Affecting Tax Exemption of Charitable Institutions*, 37 A.L.R. 3d 1191, 1197 (1971).

[51] Bozeman Deaconess Found. v. Ford, 151 Mont. 143, 439 P.2d 915, 918 (1968). *Accord*, G. BOGERT, THE LAW OF TRUSTS AND TRUSTEES §369, at 62-63 (2d ed. 1964); C. ZOLLMANN, AMERICAN LAW OF CHARITIES 121, 123 (1924); Note, *Humanitarian Approach to Taxation of Homes for the Aged*, 4 WILLAMETTE L. J. 504, 507 (1967).

section 501(c)(3) in another act, *i.e.*, whether a corporation "was organized and operated exclusively for religious, charitable, scientific, literary, or educational purposes" under section 1(b)(7) of the District of Columbia Unemployment Compensation Act, the Court of Appeals for the District of Columbia applied this fundamental principle.

> "'. . . the differing condition, character, and wants of communities and nations change and enlarge the scope of charity, and where new necessities are created new charitable uses must be established. . .'"[52]

This principle has been recognized as applicable to changes in the hospital area:

> "[r]easonable deviations and expanded interpretations must be made from time to time in order to keep pace with changes in recognized concepts of the proper sphere of general hospital operations." *Charlotte Hungerford Hosp. v. Mulvey*, 26 Conn. Sup. 394, 225 A. 2d 495, 497 (1966).

Unless the courts and the Commissioner, in recognition of their decisions, are free to recognize this basic principle of the law of charity by modifying the requirements for exemption under section 501(c)(3) in response to changing economic, technological and social conditions, the charitable exemption provided by Congress in section 501(c)(3) will surely lose its vitality and its ability to encourage new endeavors beneficial to the changing needs of man.[53]

[52] Collier v. Lindley, 203 Cal. 641, 266 P. 526, 528 (1928), cited in Int'l Reform Fed'n v. Dist. Unemployment Comp. Bd., 131 F.2d 337, 339 (D.C. Cir. 1942). *Accord*, Green v. Connally, 330 F. Supp. 1150, 1158-59 (D. D.C. 1971); Todd v. Citizens Gas Co., 46 F.2d 855, 965, (7th Cir.), *cert. denied*, 283 U.S. 852 (1931): "[t]he enforcement of charitable uses cannot be limited to any narrow and stated formula. It must expand with the advancement of civilization and the daily increasing needs of man."

[53] R. BROMBERG, *Charity and Change: Current Problems of Tax Exempt Organizations in Perspective*, TAX PROBLEMS OF

(Footnote continued on following page)

B. Early Hospitals Were Almshouses.

From its inception, the hospital was principally a custodial institution for unwanted members of society—the sick, the poor, the wanderers, the displaced, the incurables and the infectious.[54] Its principal purpose was to serve the indigent, with medical care being incidental.

The first hospitals in America were said to be "pest houses" for sailors with contagious diseases, one being established in Manhattan in 1663 and one in Philadelphia in 1731.[55] The Philadelphia General Hospital, which grew out of the Philadelphia Almshouse founded in 1713, and its early successors during the 18th century were essentially almshouses and provided facilities for indigents, criminals, foundlings, the physically handicapped, and the mentally unbalanced.

Our early "charitable" hospitals were not institutions primarily concerned with delivering health care to the sick, but were basically almshouses providing the barest

(Continued from previous page)

CHARITIES 1970 249 (Webster & Lehrfeld eds. 1970). Some recent examples of organizations which have been held exempt under section 501 (c) (3), even though their purposes, or their means of achieving them, were not recognized as charitable under prior law are: public interest law firms, Rev. Proc. 71-39, 1971-2 CUM. BULL. 575; women's liberation organizations, Rev. Rul. 72-228, 1972-1 CUM. BULL. 148; day care centers, Rev. Rul. 70-533, 1970-2 CUM. BULL. 112; drug abuse centers, Rev. Rul. 70-590, 1970-2 CUM. BULL. 116; environmental protection organizations, Rev. Rul. 72-560, 1972-2 CUM. BULL. 248; home health care organizations, Rev. Rul. 72-209, 1972-1 CUM. BULL. 148; marriage counseling organizations, Rev. Rul. 70-640, 1970-2 CUM. BULL. 117; community land use planning organizations, Rev. Rul. 67-391, 1967-2 CUM. BULL. 190; and abortion counseling organizations, Rev. Rul. 73-569, 1973-2 CUM. BULL. 178.

[54] The oldest known hospital in Western Europe was the Hotel Dieu, founded at Lyons in 542 A.D. It served as an inn, workhouse, asylum and infirmary. *See* C. LETOURNEAU, HOSPITAL TRUSTEESHIP 4 (1959); COMM'N ON HOSPITAL CARE, HOSPITAL CARE IN THE UNITED STATES 425 (1947); J. KNOWLES, HOSPITALS, DOCTORS AND THE PUBLIC INTEREST (1965).

[55] *See* MARTS, THE GENEROSITY OF AMERICANS 114-15 (1966).

refuge for the poor members of society who had no place else to go.[56] Pay patients were unheard of because those who could afford care remained at home to avoid the harsh and unsanitary conditions in these early "charitable" institutions.[57].

The origin of American hospitals as almshouses was reflected in the law of charities well into the early part of the 20th century. Decisions dealing with the definition of a charitable hospital had little difficulty in characterizing such institutions as organizations dedicated exclusively to the care of the poor and indigent since this, in fact, was precisely how these institutions had functioned in Europe and America. Thus, charitable hospitals were frequently indistinguishable from almshouses in early legal definitions. For example, in construing an exemption from taxation for every "poor-house, house of industry, *almshouse*, and every house belonging to a company incorporated for the reformation of offenders," a New York Court found that a private hospital qualified as an almshouse. *In re Curtis' Est.*, 1 Con. 471, 7 N.Y.S. 207 (Surr. Ct. 1889).[58] As

[56] E. FISCH, D. FREED AND E. SCHACHTER, CHARITIES AND CHARITABLE FOUNDATIONS §322 (1974). The workhouse for the impecunious aged was the historic antecedent for today's homes for the aged, posing a similar problem for the self-supporting home for the aged of today.

[57] Bromberg, *The Charitable Hospital*, 20 CATH. U. L. REV. 237 (1970). As noted by one authority:

> "General hospitals were established in the United States as early as the eighteenth century to serve the sick poor, and offer a roof and bed for the homeless or for those whose homes were inadequate. These institutions were primarily the last resort of the sick. Their standards of care did not approach those for the simplest custodial care today. Hospital cleanliness was unknown, nursing was unskilled, equipment did not even include the clinical thermometer." *Factors Affecting the Costs of Hospital Care*, 1 FINANCING HOSPITAL CARE IN THE UNITED STATES 9 (J. Hayes, ed. 1954).

[58] *Factors Affecting the Costs of Hospital Care*, 1 FINANCING HOSPITAL CARE IN THE UNITED STATES (J. Hayes, ed. 1954).

(Footnote continued on following page)

late as 1926, the Supreme Court of Oklahoma held that " '[a] public hospital is a charitable institution, or under some statutes, an almshouse, so as to be exempt from taxation. . .' " *S.W. Osteopathic Sanitarium v. Davis*, 242 P. 1033, 1034 (Okla. 1926).

In view of the historic role of the hospital as an almshouse, it is not difficult to understand the derivation of the common law rule that "[t]he first concern of a public charitable hospital must be for those who are unable to pay." *O'Brien v. Physicians' Hosp. Assoc.*, 96 Ohio St. 1, 116 N.E. 975, 977 (1917). Similarly, in view of the fact that any person able to afford medical care would avoid these early institutions which functioned solely for the poor, it is not surprising that a companion rule developed that the presence of pay patients was antithetical to exemption of hospitals as charitable institutions.[59]

(Continued from previous page)

"The primary meaning of the word 'hospital' for instance, was an inn. . . . Now the word is more commonly applied to a building founded for charity, where the sick and disabled may be treated solely at their own expense, or at the expense of the Corporation which receives only indigent patients, *and then has all the attributes of an almshouse*, and in either case it becomes, as we understand the terms, a charitable institution." (Emphasis supplied.)

[59] In deciding that a nonprofit hospital was not charitable, the Supreme Court of Mississippi quoted with approval the stipulated statement of facts:

" 'From time to time, [the hospital] treats charity patients, but care of such patients is not its principal purpose; its primary purpose is to care for and treat patients for pay. Its entire property is devoted to the care of the sick, and to those who require medical or surgical treatment.' " Mayor and Aldermen of City of Vicksburg v. Vicksburg Sanitarium, 117 Miss. 709, 78 So. 702 (1918).

Similarly, as late as 1933, the Supreme Court of Georgia held that a hospital supported in substantial part by donations and largely by income derived from pay-patients received in the hospital is not within the exemption for institutions of purely public charity, although it also received without charge certain patients who are unable to pay. Richardson v. Exec. Comm. of Baptist Conv., 176 Ga. 705, 169 S.E. 18 (1933).

The correlative of these rules reflecting the almshouse or pesthouse function of the charitable hospital was that private contributions would be received by these institutions to underwrite the cost of caring for the poor.[60] Although tax funds contributed to their operations, philanthropy and endowment earnings were also important sources of financing the cost of indigent care.[61]

This pattern of financing the cost of health care for the poor was also reflected in our early decisions. In 1881 the Supreme Court of Minnesota held "that an institution established, maintained and operated for the purpose of taking care of the sick, without any profit, or view to profit, but at a loss which has to be *made up by benevolent contributions*, is a charity." *In re Lots 8 and 9*, 27 Minn. 460 (1881)[62] (emphasis supplied). Thus, in response to the modus operandi of our early voluntary nonprofit hospitals, American case law reflects certain basic criteria for qualification of nonprofit hospitals as charitable institutions:

(1) Their primary concern must be with indigent patients;

---

[60] "Voluntary hospitals were a form of charitable agency not connected with church or state. They were founded by gifts and subscriptions collected from donors who have an interest and pride in civic affairs and a desire to participate in philanthropy. They were maintained by these funds. . . ." COMM'N ON HOSPITAL CARE OF THE COMMONWEALTH FOUNDATION, HOSPITAL CARE IN THE UNITED STATES 442 (1947).

[61] "At the end of the nineteenth century there were a few private institutions of the sanitarium type exclusively for pay patients, but the great majority of hospital patients were still the poor who received their care free or who paid only a portion of the cost. Tax funds, philanthropy and endowment earnings were the chief sources of hospital financing." *Factors Affecting the Costs of Hospital Care*, 1 FINANCING HOSPITAL CARE IN THE UNITED STATES 12 (J. Hayes, ed. 1954); *see also* MCNERNEY, *Health Research and Educational Trusts*, 1 HOSPITAL AND MEDICAL ECONOMICS 92 (1962).

[62] "A hospital which pays no dividends and is largely supported by donations is a charitable institution." *In re* Prange's Will, 208 Wis. 404, 243 N.W. 488, 491 (1932).

(2) They may not serve a substantial number of pay patients;

(3) They are required to provide a substantial amount of free care; and

(4) They are required to receive contributions and maintain endowments to underwrite the cost of caring for the poor.

C. Voluntary Hospitals Began to Develop into Community Health Facilities During the 19th and Early 20th Centuries.

The 19th century brought the beginning of two major changes in hospital care in America. The first was the development in the early part of the century of the voluntary hospital with its community, rather than indigent, orientation. The second, which began in the latter part of the 19th and continued over into this century, was the improvement of conditions in hospitals.

By the middle of the 19th century, a number of voluntary hospitals had developed in this country. Unlike the older almshouse form of institution, their primary purpose was to serve the sick and injured regardless of economic status, race, color or creed.[63] By the end of the 19th century, the need for voluntary hospitals increased significantly as a result of the introduction of new services such as asepsis and anesthesia.[64] By the turn of the century, hospital

[63] COMM'N ON HOSPITAL CARE OF THE COMMONWEALTH FOUNDATION, HOSPITAL CARE IN THE UNITED STATES 442 (1947).

[64] "One might say that the period from 1880 to 1910 was the golden era of hospital progress and development. It was in that period that modern medical diagnostic techniques and aseptic surgery were developed; professionalism and specialization were brought to anesthesia and to the clinical laboratory. Roentgenology was invented and introduced as a common diagnostic tool.

"These advances led to the expansion of hospital utilization. Facilities were developed for private patients. Any physician

(Footnote continued on following page)

services began to include expert nursing, diagnostic x-rays, protection against infection, clinical laboratory service, anesthesia and aseptic surgery.[65] Thus, hospitals became community health facilities.

Accompanying this change in function of the hospital from almshouse to a community health facility was a gradual change in the sources of its financial support. Whereas during the last century and the early part of this century, gifts, endowments and tax funds were of greater importance to the operation of voluntary nonprofit hospitals,[66] income from patients began to assume greater significance as hospitals began to be accepted and utilized by the great middle class.[67]

(Continued from previous page)

who wanted the full resources of modern diagnosis and treatment had to have a hospital staff appointment. *The hospital changed from a place caring for the transient and the poor to a place where special services of diagnosis and treatment were available to the physician's patients—the poor and wealthy alike.* From 1873 to 1909, the number of hospitals increased from 178 to 4,359." I. BELKNAP AND J. STEINLE, THE COMMUNITY AND ITS HOSPITALS 13 (1963).

[65] COMM'N ON HOSPITAL CARE OF THE COMMONWEALTH FOUNDATION, HOSPITAL CARE IN UNITED STATES 447 (1947):

> "[T]he public came to realize that certain forms of disease and injury could be better treated in hospitals than in their own homes. By the end of the century, hospitals were admitting increasing numbers of paying patients in special wards and rooms set apart from those for the destitute. Advances in medical science and nursing care gave infallible proof to the public that hospitals were essential to the health of the community."

[66] McNERNY, *Health Research and Education Trusts*, 1 HOSPITAL AND MEDICAL ECONOMICS 9 (1962).

[67] Prior to 1900, the earnings for patients' fees in hospitals holding membership in the United Hospital Fund of New York City covered but a third of the expenses, but thirty years later, the figure was sufficient to meet two-thirds of the cost of operations. The percentage of income from paying-patients throughout the century doubled in a generation. M. DAVIS, CLINICS, HOSPITALS AND HEALTH CENTERS 13 (1927).

However, during the 19th century and continuing into this century, the patient in the private room was not merely a "pay patient," but was in reality an "overpay" patient in accordance with the Robin Hood theory that persons able to pay should be charged enough to supplement the funds available for hospital care of the poor. This was the beginning of the trend toward less reliance by charitable hospitals upon voluntary philanthropy and more reliance upon involuntary philanthropy in the form of overcharges to pay patients to cover the cost of operating expenses for indigent care. The social welfare legislation under which the Government began to assume a substantial part of the cost of indigent care on a wide-spread basis had not yet flowered.[68]

Thus, moving into the middle of the 20th century, the voluntary hospital had changed its function to a community health facility available to pay patients. Its sources of financing indigent care, although still dependent upon philanthropy, had shifted toward using receipts from the excess of charges to pay patients over the cost of the services rendered.

This transition was also reflected in the attitude of the law of charity towards the charitable hospital. Moving away from the position that the presence of pay patients is antithetical charitable status, a new rule developed in the law.

> "[T]he mere fact that pay patients predominate over those unable to pay, and that charges are made for drugs furnished those of the patients able to pay for them, and that charges are made against those able to pay for the use of the operating rooms, does not destroy or impair the exclusiveness of the use of the property by the [hospital], nor does it change the character of the institution from one of purely public charity." *Santa Rosa Infirmary v. City of San Antonio*, 259 S.W. 926, 934-35 (Comm. App. Tex. 1924).[69]

Courts began to reject the argument that a "hospital should not be held to be an institution of public charity by reason of the great disparity between the number of charity patients and those who pay for the care and attention they receive at this institution." *Sisters of Third Order of St. Francis v. Bd. of Rev.*, 231 Ill. 317, 83 N.E. 272, 273-74 (1907).

In recognition of the fact that nonprofit hospitals had now begun to serve paying patients, instead of only indigents, the concept developed that a charitable hospital was one which served the rich as well as the poor.[70] The classic statement of this rule, as enunciated in *Nuns of Third Order of St. Dominic v. Younkin*, is:

> "When an institution is incorporated for benevolent purposes without capital stock, and no dividends are declared or paid, and conducts a hospital, and all the earnings of the hospital from pay patients, gifts, devises, bequests or whatever source are used in the maintenance, extension and improvement of the hospital, and which admits patients without regard to race, creed, or wealth, it is uniformly held that such hospital is conducted exclusively for charitable purposes." 118 Kan. 554, 235 P. 869, 872 (1925).[71]

---

[68] E. FISCH, D. FREED AND E. SCHACHTER, CHARITIES AND CHARITABLE FOUNDATIONS §322, at 274 (1974):

> "During the middle of the past century, hospitals began to change from asylums for the poor to large centers where physicians furnished expert medical services to all who required medical attention. Gradually, the government entered into the field of health and hospitals began to receive financial support from public sources." (Footnote omitted.)

[69] *Accord*, Dingwell v. Seymour, 91 Cal. App. 483, 267 P. 327 (1928); State *ex rel.* Cunningham v. Bd. of Assessors, 52 La. Ann. 223, 26 So. 872 (1898).

[70] *See* Pl. Br. at 29.

[71] *Accord*, Bishop v. Treas., 37 Colo. 378, 86 P. 1021 (1906); Sisters of Third Order of St. Francis v. Bd. of Rev., 231 Ill. 317, 83

(Footnote continued on following page)

At the same time that the courts were sanctioning the use of charitable hospitals for paying patients, they began to develop the doctrine that a nonprofit hospital, free of private benefit or profit, was, per se a charitable institution. This doctrine reflected both the well-established legal premise (discussed above) that the promotion of health is a charitable purpose and the fact that pay patients had now become a source of funding hospital operations.

While the earliest expression of this concept was directed towards the use of excess charges to pay patients to fund free care,[72] as hospitals continued to develop into the 20th century and expand their functions as the community health facility, the rule began to evolve into the present state of the law's recognition that a nonprofit hospital, free of private profit, can qualify as charitable, even if it charges all patients.[73] This is the derivation of the rule enunciated by Scott and other treatise writers that

(Continued from previous page)

N.E. 272 (1907); German Hosp. v. Bd. of Rev., 233 Ill. 246, 84 N.E. 215 (1908); State *ex rel.* Alexian Bros. Hosp. v. Powers, 74 Mo. 476 (1881); State v. Collector of Chatham, 52 N.J.L. 373, 20 A. 292 (1890). To the same effect under Federal law, *see* Gossett v. Swinney, 53 F.2d 772, 776 (8th Cir. 1931), *cert. denied*, 286 U.S. 545 (1932):

"Perhaps charity, as generally and commonly understood, has to do with gifts to the poor and needy, and steps taken to relieve distress and suffering on the part of those unable to help themselves; but the legal significance of the term is much broader. Public charities are thus defined: 'Every public trust, though benefiting the rich and the poor alike, is a charitable trust.'"

[72] "The increase of charitable funds, through receipts from patients or inmates who are able to pay wholly or partially for benefits received, does not change a home for aged people, or hospital, organized and conducted as a charity, into a private association, maintained for the pecuniary advantage of the promoters. The originally eleemosynary character of the institution is not transformed by this patronage, even if sufficient to relieve it from financial burdens, but the charity as established remains unaffected." New England Sanitarium v. Inhabitants of Stoneham, 205 Mass. 335, 91 N.E. 385, 387 (1910).

[73] As early as 1934, in a landmark case in the law of charity,

(Footnote continued on following page)

"[a] trust to establish or maintain an institution may be charitable, however, although it is provided that some or *all* of the persons to receive benefits from the institution are to pay fees or otherwise contribute to the expense of maintaining the institution." (Emphasis supplied.)[74]

D. The Financing of Hospital Care Has Shifted to Reimbursement by Private and Governmental Third Parties.

The modern legal view of a charitable hospital reflects not only the evolution of the voluntary hospital from

(Continued from previous page)

the Supreme Court of Vermont held: "The fact that none of its [the hospital's] patients are cared for without charge does not deprive it of its charitable feature." Brattleboro Retreat v. Town of Brattleboro, 106 Vt. 228, 173 A. 209, 212 (1934).

In another case from the same period, the Supreme Court of Texas stated:

"[T]he mere fact that pay patients largely predominated over the charity patients, or that the institution did not go out into the highways and byways seeking out those to whom its charitable offices might be extended, could not, under the great weight of authority, be said to so detract from its charities as to disqualify it as an institution of purely public charity." Santa Rosa Infirmary v. City of San Antonio, 259 S.W. 926, 932 (Comm. App. Tex. 1924).

Even the Supreme Court of Ohio appears to have recognized the transition in the role of the community hospital by moving away from the rule that "the *first concern* of a public charitable hospital must be for those who are unable to pay" (O'Brien v. Physicians' Hosp. Assoc., 96 Ohio St. 1, 116 N.E. 975, 977 (1917) (emphasis supplied)) to the rule that "a hospital to qualify as a charitable institution, the property of which is exempt from taxation, should have as *an important objective* the care of the poor, needy and distressed who are unable to pay, although the fact that it admits and ministers to a number of pay patients will not necessarily destroy its charitable character." Cleveland Osteopathic Hospital v. Zangerle, 153 Ohio St. 222, 91 N.E.2d 261, 264 (1950).

[74] A. Scott, The Law of Trusts §376, at 2966 (3d ed. 1967); *see also id.* at 2966-68 n. 3; C. Zollmann, American Law of Charities §714-15 (1924).

almshouse to community health facility, but more importantly the evolution of the means of financing hospital care. As we move into the last half of the 20th century, further important changes occurred in the delivery of hospital care. These include:

(1) A rapid increase in patient income, with a corresponding increase in the percentage of expenses covered by revenues from paying patients as compared to revenues from charitable contributions.[75]

(2) A substantial increase in the cost of hospital care because of higher wages and improved medical technology.[76]

(3) The rapid growth of health insurance to meet the increasing costs of hospital and medical care.[77]

---

[75] "The most significant shift in the source of income of nonprofit general hospitals was the sharp increase in the proportion of funds received from or on behalf of patients. Income from patients made up 71 percent of total income in 1935, but accounted for 89 percent in 1952. Total patient income increased 746 percent over this 17 year period, contrasted with an increase of only 163 percent in income from all other sources." *Factors Affecting the Costs of Hospital Care*, 1 FINANCING HOSPITAL CARE IN THE UNITED STATES 53 (J. Hayes, ed. 1954).

[76] G. BAEHR, *Medical Care: Old Goals and New Horizons*, 3 MEDICAL CARE AND TRANSITION 326 (1967); DEPT. HEALTH, EDUC. & WELFARE, REPORT OF SECRETARY'S ADVISORY COMM. ON HOSP. EFFECTIVENESS 6 (1968).

[77] *See* H. KLARMAN, THE ECONOMICS OF HEALTH 31 (1965). By 1940 only 9.3% of our population had some form of hospital insurance. Mueller, *Private Health Insurance in 1973: A Review of Coverage, Enrollment and Financial Experience*, 38 Soc. Sec. BULL. 21, at 26, Table 6 (Feb. 1975); DENSON, BALAMUTT AND SHAPIRO, PREPAID MEDICAL CARE AND HOSPITAL UTILIZATION 1 (1958). However by 1973, under estimates of the Health Insurance Association of America, approximately 87.1% of the civilian population was covered by some form of private health insurance. Mueller, *Private Health Insurance in 1973*, *supra* at 26, Table 6 (Feb. 1975). Even these figures do not include persons eligible for health insurance under Medicare. In 1970, it is

(Footnote continued on following page)

(4) The rapid growth of health insurance coverage for the poor under Medicare and Medicaid.[78]

(5) The resulting decline in the percentage of free or below-cost patients requiring hospital care.[79]

In the light of these changes, the common law rules developed for charitable hospitals of the 18th and 19th centuries, being primarily concerned with free care to indigents, are no longer applicable to community hospitals in 1975. In recognition of the importance of health care to its citizens, federal, state and local governments, through the enactment of legislation providing reimbursement to

---

(Continued from previous page)

estimated that an additional .59% of those not otherwise covered by health insurance received benefits under Medicare (Department of Commerce figures from A GUIDE TO CONSUMER MARKETS, CONFERENCE BOARD REPORT, No. 67, at 140), and another 8.6% received benefits under Medicaid (NUMBER OF RECIPIENTS AND AMOUNTS OF PAYMENTS UNDER MEDICAID 1970, DHEW Publ. No. (SRS) 73-03153MCSS Report B-41(CY 70) p. 1). Thus during the early 1970's estimated figures indicate that some form of health insurance coverage, either private or public, was available to over an estimated 96% of the population.

[78] Cantor, *The Law and the Poor People's Access to Health Care*, 35 LAW & CONTEM. PROB. 901, 914 (1970):

> "At the same time as the focus of hospital patient care was shifting from the poor population toward the general public, the source of hospital funding was changing. Massive infusions of public monies began, ending the reliance on private contributions and eventually reaching the point where today approximately fifty per cent of the private hospitals' operating funds are derived from governmental sources."

In 1973, Medicaid payments were made on behalf of an estimated 20.9 million persons. Mueller, *Private Health Insurance in 1973: A Review of Coverage, Enrollment and Financial Experience*, *supra* at 22. As of January 1, 1973, the total number enrolled for hospital care under Medicare was 21 million people.

[79] "The decrease in charity service provided by hospitals may have resulted in part from a tendency in some areas for government to assume greater responsibility for the care of the indigent through direct payment for individual Cases . . . " *Factors Affecting the Costs of Hospital Care*, 1 FINANCING HOSPITAL CARE IN THE UNITED STATES 56 (J. Hayes, ed. 1954).

health care providers[80] and the maintenance of a system of public hospitals, have evidenced an increasing acceptance

[80] The number of persons covered by Medicare can be readily determined by looking to the number of persons enrolled in the program. However, since Medicaid coverage is available to all persons who come within the state requirements for coverage, an indigent person eligible for Medicaid, but has not become sick and availed himself of its benefits, will not be reflected in statistics showing the number of Medicaid recipients. Because eligibility for benefits is thus greater than the number of persons who actually receive such benefits, it is not possible to make a precise estimate of the percentage of the population covered. This, and other factors, suggest that a greater number of persons are covered by some health insurance or are otherwise able to pay at least part of the costs of their hospital care than is suggested by plaintiffs (Pl. Br. at 33).

> "Undoubtedly, some Americans who could afford to buy private health insurance choose not to do so. Many other persons receive assistance with these costs through such programs as Medicaid (medical assistance), the civilian health and medical care program for the uniformed services (CHAMPUS), the Veterans Administration Program, State disability insurance programs, and workmen's compensation." Mueller, *Private Health Insurance in 1973: A Review of Coverage, Enrollment and Financial Experience*, 38 Soc. Sec. Bull. 21, 21-22 (Feb. 1975).

Nevertheless, it is not disputed that some Americans are lacking in coverage, or are otherwise unable to pay the full costs of hospital care. What is significant for purposes of the issue before the Court, however, is not the diminishing percentage of persons who are not covered, but rather the dramatic expansion between 1940 and 1973 of coverage from 9% to in excess of an estimated 87% of our population (approximately 96.29% if estimated Medicare and Medicaid coverage is included), and the continuing decrease in the number of patients for whom reimbursement is not available under government programs. These are facts that our courts have taken notice of in evolving a contemporary definition of the charitable hospital. It is these same facts, and the case law reflecting them, that provide a sound legal basis for *Rev. Rul. 69-545*. It is further noted that the enactment of national health insurance is only a matter of time. It will moot the issue before the Court and dramatically illustrate the decline of the charity patient. The free care test for charitable exemption asserted by plaintiffs is totally incompatible with any program of national health insurance and could not be administered by the IRS in such climate on any meaningful basis.

of the role of government in this area[81] and have shifted the burden of paying for free care from private philanthropy.

Although there admittedly are still persons for whom no reimbursement is available, voluntary hospitals' ability to finance the cost of free care for this unfortunate minority has been sharply reduced. Philanthropy initially sustained the cost of free care during the early development of our hospitals, but by 1973 it provided only about 4% of the total health costs, approximately 2/3 of which was earmarked for construction and modernization of facilities, and therefore was not available for operating fund purposes, which includes medical care, research and indigent care."[82]

[81] In *Mem'l Hosp. v. Maricopa County*, 415 U.S. 250 (1974), the Court has insisted that local government assume this burden, while noting the financial plight on voluntary hospitals attempting to share in it.

[82] American Assoc. of Fund Raising Council, Inc., Giving U.S.A. 34 (1973). Of this 4%, approximately 60% is generally spent for hospital construction and modernization of facilities leaving only about 1.3% of philanthropic funds available for all operating needs, including indigent care. *See* Hearings on Medicare and Medicaid before the Subcomm. on Medicare-Medicaid of the Senate Comm. on Finance (Part 2), 91st Cong., 2d Sess. 422 (1970). In fact, "the need for capital is outstripping the philanthropic supply." Walls, *Cost Reimbursement Worsens Capital Crisis*, 46 Hospitals 81 (March 1, 1972).

> "The image of a voluntary institution as a charitable organization, financing its care of patients to a substantial degree through philanthropy . . . is largely anachronistic. Philanthropy, through increasing, has not been able to match the redoubled demands for health care."

Statement of Professor William Thomas, Hearings on Conditions and Problems of the Nation's Nursing Homes. Subcomm. on Long-Term Care, Special Comm. on Aging, U.S. Sen., (Part 2), 89th Cong., 1st Sess., 559 (Feb. 15, 1965).

> "Yet hospitals were historically founded to meet the medical needs of the sick poor. In accordance with the philanthropic motivations of their founders, the charters of innumerable private 'charitable' hospitals explicitly required the rendering of care to all patients who needed assistance, including

(Footnote continued on following page)

The impossibility of meeting the demands for free care of indigents through philanthropy can be simply illustrated by comparing the 4% of cost of health care met by philanthropy in 1973 with the 23.6 million persons plaintiffs claim need free care. Pl. Br. at 33-34.[83]

The hospitals' other traditional means of financing free care through shifting the burden upon patients paying more than the cost of their own hospital care has also been drastically diminished. Medicare and Medicaid universally, and Blue Cross plans generally, provide reimbursement on the basis of cost. The cost of indigent care is excluded from the reimbursement formula. Only commercial plans and private paying patients pay in excess of cost.

Accordingly, the percentage of hospital expenditures which are reimbursed on the basis of cost, leaving no excess to cover the cost of charitable care, has been steadily increasing, rising from 68.2% in 1970 to 72.8% in 1972.[84] Thus the 27.2% of the patients paying charges would be faced with an extraordinary burden if required to bear the cost of indigent care for an alleged 27 million people.[85]

(Continued from previous page)

the sick poor. Such institutions were sustained by the charitable contributions of the public at large. In many instances fiscal burdens have gradually impeded continuation of the hospital's charitable function and in some instances provoked complete discontinuance of 'free' care." Cantor, *The Law and Poor People's Access to Health Care*, 35 LAW & CONTEM. PROB. 901, 914 (1970) (footnotes omitted).

[83] Dividing the $800 million available for operating expenses by hospitals in 1969 (see Pl. Br. at 15) by the 23.6 million persons allegedly needing free care, only $33 per year would be available to subsidize the care of each such person. This would pay for less than one day of hospital care.

[84] 1973 AHA GUIDE TO THE HEALTH FIELDS (Aug. 1973).

[85] "When absorbed by private hospitals, the costs of caring for indigents must be passed on to paying patients and 'at a rather inconvenient time'—adding to the already astronomical costs of hospitalization which bear so heavily on the resources of most Americans." Mem'l Hosp. v. Maricopa County, 415 U.S. 250, 265 (1974).

In summary, the application of principles of the law of charity developed in the 18th and 19th centuries, which plaintiffs would have the Court impose, would require that a charitable hospital primarily concern itself with the poor, although the hospital as an almshouse disappeared nearly a century ago; that a charitable hospital not concentrate its efforts upon caring for the pay patients, although this is the modus operandi of nearly all of our hospitals today; and that service be provided free, although private health insurance, Medicare, Medicaid and other governmental assistance have diminished both the number of persons needing free care and the hospitals' ability to provide it. Due to the diminishing sources of funds to cover the costs of free care, however, voluntary nonprofit hospitals today cannot satisfactorily meet any required free care needs.

Fortunately, our courts have acted upon the fundamental principle that the law of charity must be responsive to the changing circumstances and the varying needs of the community. In recent years, one court after another has responded to the changing conditions in hospital care and in its method of financing by rejecting the free-care standard as a meaningful criterion for exemption of charitable hospitals.

In rejecting this antiquated standard, the courts have indicated an awareness of the ever increasing federal assistance available to the poor. It is highly pertinent, therefore, to review the various decisions which support the contemporary criteria for charitable hospitals set forth in *Rev. Rul. 69-545* and which firmly establish the principle that the test of a charitable institution "is not the extent of the free services rendered, nor whether the patients pay more or less than cost for the services, but whether those who operate it are doing so for private profit, directly or in-

directly."[86]

An early case containing a realistic response to some of the changing factors discussed above, i.e., an increase in the percentage of expenses covered by patient revenues compared to charitable contributions and the substantial increase in the cost of hospital care, is *Southern Methodist Hospital and Sanitarium v. Wilson,* 51 Ariz. 424, 77 P.2d 458, 461-62 (1938):

> "If, therefore, we are to insist that those who contribute with the idea that the institution which receives their funds is a charitable one, must make that contribution large enough to maintain the institution not only a charitable, but as a free one, in many, if not most, of our communities, there will be no place where the sick may be cared for under any circumstances, except the private nursing homes available only to the very wealthy, or the county hospitals for indigents."

The evolution of the law away from the free-care standard also was described in *Young Men's Christian Ass'n v. Lancaster County,* 106 Neb. 105, 182 N.W. 593 (1921), quoted with approval in *Evangelical Lutheran Good Samaritan Society v. County of Gage,* 181 Neb. 831, 151 N.W.2d 446, 449 (1967):

> "Formerly all institutions furnishing services of this nature, including both hospitals and nursing homes, were providing care for many patients without compensation and extended charity in the sense of alms giving or free services to the poor. With the advent of present-day Social Security and welfare programs, this type of charity is not often found because assistance is available to the poor under these programs. Yet . . . courts have defined 'charity' to be something more than merely alms giving or the relief of poverty and distress and have given it a significance broad enough to include practical enterprise at a good of

[86] HAYT, HAYT, & GROESCHEL, LAW OF HOSPITAL, PHYSICIAN AND PATIENT 68 (2d ed. 1952).

> humanity operated to the moderate cost to those who receive the benefits."[87]

More recently, further doubt has been cast upon the relevance of free care as a standard for charitable exemption:

> "Although 'percentages' may in some future case be controlling, total reliance on the same continues to become more questionable; because the advent of modern day social legislation has resulted in more plans to provide more citizens with assistance in paying for hospital care." *Jackson County v. State County Commissioner,* 521 S.W.2d 378, 384 (Mo. 1975).

Part of the reason for the judicial rejection of the free-care standard has been the recognition by the courts of the increasing reduction in patients needing free care because of the spread of social welfare legislation providing reimbursement for services rendered to them.[88] In *Miami Retreat Foundation v. Ervin,* 62 So. 2d 748 (Fla. 1952) it was alleged that the amount of charity work done was inconsequential and that exemption should be denied. Never-

[87] *Accord,* Evangelical Lutheran Good Samaritan Soc. v. Bd. of County Comm'rs, 219 N.W.2d 900 (N.D. 1974). Despite plaintiffs' attempts to distinguish this case as a matter of local law, one unbiased commentator had stated:

> "The decision in *Evangelical Lutheran* represents the law in the majority of American jurisdictions. In a recent decision rendered in Louisiana [Ruston Hosp., Inc. v. Riser, 191 So. 2d 665 (La. App. 1966)] the court observed that there is an increasing antithetical trend. A study of cases decided during the last ten years does not support this contention." Casenote, *Taxation—Charitable Exemptions From Real Estate Taxes—What is a Charity,* 17 DEPAUL L. REV. 433, 438 (1968) (footnotes omitted).

[88] "Moreover, it is a matter of wide knowledge in which we gladly participate that the public or general welfare policy of Pennsylvania has been increasingly broadened to include greater and greater concern for the aged and the sick and the infirm, and consequently the words 'charity' and 'public charity' must be given a liberal interpretation." *In re* United Presbyterian Homes, 428 Pa. 145, 236 A.2d 776, 779 (1968).

theless, the shift from indigent care to reimbursement was acknowledged and the organization held to be charitable.

> "[M]ost of the persons who would in the normal course of events be admitted as charity patients are accommodated as County patients, and such accommodations paid for by the county. True, they are not received as charity patients, and as a matter of fact, are the chief source of revenue and profit of the Corporation. But in a large measure this accounts for the failure of charity patients to present themselves for admission." *Id.* at 752.[89]

In the light of expanding social welfare programs and the decline in the number of persons for whom reimbursement is not available, our courts have increased their criticism of basing charitable exemption on free care. This is especially true due to the administrative difficulties in applying any free-care standard.

> "A tax exemption cannot depend on any such vague and illusory concept as the percentage of free service actually rendered. This would produce chaotic uncertainty and infinite confusion, permitting a hodgepodge of views on that subject." *City of Richmond v.*

[89] Similarly, in *Evangelical Lutheran Good Samaritan Soc. v. Bd. of County Comm'rs*, 219 N.W.2d 900, 908 (N.D. 1974), the Supreme Court of North Dakota stated:

> "In earlier years, before the advent of modern welfare programs, many persons sought free care from institutions such as those the Society maintains. However, today welfare programs are widespread and a matter of right."

The Supreme Court of Vermont has observed:

> "It may well be that under present and future economic conditions, social welfare programs, or other benefits, few, if any persons residing in Bennington County, or elsewhere, could be considered destitute." Destitute of Bennington County v. Henry W. Putman Mem'l Hosp., 135 Vt. 289, 215 A.2d 134, 142 (1965).

In another recent case decided by the Supreme Court of Arkansas, although the tax assessor argued that "only three charity patients have been treated at the hospital," the hospital

(Footnote continued on following page)

Richmond Mem'l Hosp., 202 Va. 86, 116 S.E.2d 79, 81-82 (1960).[90]

To avoid the administrative uncertainty and confusion in applying a free care standard, such as contained in *Rev. Rul. 56-185*, our courts have accepted the rule that "without doing any free work of any kind, [a] hospital would still be a charitable corporation so long as the surplus income is applied to the support, maintenance and enlargement of the hospital and its facilities." *Weiss v. Swedish Hospital*, 16 Wash. 2d 446, 133 P.2d 978, 980 (1943); *In re Henderson's Est.*, 17 Cal. 2d 853, 112 P.2d 605, 608 (1941); *City of Richmond v. Richmond Mem'l Hosp.*, 202 Va. 86, 116 S.E.2d 79, 84 (1960).[91] Health law

(Continued from previous page)

had admitted approximately 2,000 patients under Medicare, as well as providing services under Medicaid. Despite the negligible number of patients traditionally regarded as charitable, the hospital was held to be exempt from property taxes as a charitable institution. The court noted that "there would have been a great many more purely public charity cases, had it not been for Medicare payments." Burgess v. Four States Mem'l Hosp., 250 Ark. 485, 465 S.W.2d 693, 697 (1971).

[90] *Accord*, Southern Methodist Hospital and Sanitarium v. Wilson, 51 Ariz. 424, 77 P.2d 458, 462 (1938). "[T]he position that the test of a charitable institution is the extent of the free services rendered, is difficult of application and unsound in theory."

> [91] "[W]e think the institution is properly characterized as a charitable one, notwithstanding the fact that it charges for most, *if not all*, of the services which it may render, so long as its receipts are devoted to the necessary maintenance of the institution and the carrying out of the purpose for which it was organized." *Id.* (emphasis supplied), quoted with approval in Benton County v. Allen, 170 Ore. 481, 133 P.2d 991, 994-95 (1943).
>
> "Whether these hospitals are 'conducted not for profit, but exclusively as charities,' within the meaning of the constitutional provision, depends not upon the number of patients who were treated free of charge, but the nature of the institutions and the purpose of their operations." City of Richmond v. Richmond Mem'l Hosp., 202 Va. 86, 116 S.E.2d 79, 82 (1960).

(Footnote continued on following page)

treatises reflect a similar view of the present state of the law:

> "To say that the test of a charitable hospital is the amount of free service rendered is to apply a standard which is impractical and unsound . . . Free service is not a prerequisite to tax exemption and the legal meaning of charitable purposes not limited to the care of the indigent." HAYT, HAYT, & GROESCHEL, LAW OF HOSPITAL, PHYSICIAN AND PATIENT 68 (2d ed. 1952); *Accord*, HOSPITAL LAW MANUAL, *Taxation-State* I: 25 (1973).

In the face of these decisions, which comprise the general law of charity in the United States today under which section 501(c)(3) must be interpreted, the Commissioner cannot be said to have been acting outside the scope of his authority in publishing a revenue ruling which modified an earlier requirement for the rendition of free or below-cost care. *Rev. Rul. 69-545* properly reflects the widespread changes in the law of charity brought about by social, economic and technological changes over the past number of years.

(Continued from previous page)

The court further noted that:

> "There is no wording in [the statute] requiring free care or free service. The phrase 'exclusively as charities' describes the institutions entitled to exemption. It does not designate whether the services rendered by them shall be free to the recipients. If the framers of the Constitution had so intended it would have been easy and natural to have specified the rendering of free service as the basis for the exemption." *Id.*

The court then stated:

> "The legal interpretation of the phrase 'not for profit, but exclusively as charities,' is not controlled by free service to the indigent or poor. Nonprofit hospitals which are devoted to the care of the sick, which aid in maintaining public health, and contribute to the advancement of medical science, are and should be regarded as charities." *Id.* at 84.

III. REV. RUL. 69-545 IS CONSISTENT WITH FEDERAL CASE LAW PERTAINING TO TAX EXEMPTION OF NONPROFIT HOSPITALS.

A. Federal Case Law Adjudicating Exempt Status of Nonprofit Hospitals Has Been Directed Toward the Question of the Presence or Absence of Private Benefit Rather Than the Amount of Free Care.

A fundamental principle in charitable trust law is that in order to qualify as charitable, an organization must not only operate in furtherance of charitable purposes, but must also be free of any private benefit.[92] With respect to hospitals, "[t]he test [for tax exemption] is not whether the patients of the hospital pay more or less for their services, but whether those charged with its operations were conducting it for their private profit or advantage."[93]

Rev. Rul. 69-545 sets forth standards which are consistent with the body of law developed from this principle. In asserting that "[e]very Federal tax case has considered service to persons unable to pay as a *sine qua non* of 'charitable' status for nonprofit hospitals,"[94] plaintiffs have misstated the law and have ignored the plain meaning of *Rev. Rul. 69-545* which is consistent with that body of law.

The presence or absence of free care (or the amount of free care rendered) has not been dispositive of a single Federal case. As plaintiffs have indicated,[95] no Federal

---

[92] "The controlling feature is whether the institution was built, organized, and/or is maintained with an intent to make a private profit . . . ." State v. Browning, 192 Minn. 25, 255 N.W. 254 (1934). See discussion in Bromberg, *The Charitable Hospital*, 20 CATH. U. L. REV. 237, 251 et seq. (1970).

[93] So. Methodist Hosp. and Sanitarium v. Wilson, 51 Ariz. 424, 77 P.2d 458, 462-63 (1938); Benton County v. Allen, 170 Ore. 481, 133 P.2d 991 (1943); McDonald v. Mass. Gen'l Hosp., 120 Mass. 432. 21 Am. Rep. 529 (1876).

[94] Pl. Br. at 24.

[95] *Id.*

case has ever specifically held that a nonprofit hospital which limited general hospital care exclusively to persons able to pay is charitable. However, it is equally true that no Federal case has ever denied a nonprofit hospital tax exemption under section 501(c)(3) solely on the basis that it did not render free care.[96] Rather, the Federal cases have consistently recognized that all factors must be considered,[97] and they have focused on evidence determining the presence or absence of private benefit or profit.

For example, in *Sonora Community Hospital*, 46 T.C. 519 (1966), *aff'd per curiam*, 397 F.2d 814 (9th Cir. 1968), the founders of the original proprietary institution, which converted to nonprofit status, continued to control the nonprofit organization and diverted a substantial part of the hospital's income to themselves through private arrangements with its departments. The Tax Court found that "the hospital was operated to a considerable extent for the benefit of the founding doctors . . ." and therefore denied exemption.

Similarly, in *Lorain Avenue Clinic*, 31 T.C. 141, 160 (1958), the Tax Court, in denying exemption, found that the clinic "was operated for profit by a small family group; that operations for profit were petitioner's predominant

[96] A careful reading of the Federal cases cited by plaintiffs reveals that the IRS has *never* litigated a case involving a nonprofit hospital where the question of private benefit to the dominant group of physicians, shareholders, or directors was not involved.

[97] Harding Hosp., Inc. v. United States, 505 F.2d 1068, 1077 (6th Cir. 1975):

> "We do not single out any one or combination of these factors as the consideration crucial to our holding. We conclude only that all these factors, as they occurred in the aggregate in this case, require denying the appellant Hospital the tax exemption for the years in question."

Accord, Maynard Hosp., Inc., 52 T.C. 1006, 1030 (1969); Sonora Commun. Hosp., 46 T.C. 519 (1966), *aff'd per curiam*, 397 F.2d 814 (9th Cir. 1968).

activity . . . ." Most recently, in *Harding Hospital, Inc. v. United States*, 505 F.2d 1068 (6th Cir. 1975), the Sixth Circuit denied exemption to a hospital, the operations of which were permeated with evidence of private benefit. Three of the five factors on which the court based its denial of exemption involved evidence that the doctors controlling the hospital were operating it for their private benefit.[98]

In other Federal cases where the Government has attacked a hospital's exemption based upon the existence of private benefit, the presence of free care provided evidence of an absence of private benefit or profit. In the absence of other evidence of private benefit, the hospitals were accordingly held exempt. For example, in *Intercity Hospital Association v. Squire*, 56 F. Supp. 472 (W.D. Wash. 1944), involving the conversion of a profit-making hospital to a nonprofit one, the presence of a liberal rule for the admission of indigent patients enabled the hospital to overcome the Government's contention that there had been no real change in its methods and practices from those of its predecessor, a private profit corporation.[99] Similarly, in

[98] Other Federal cases involving hospitals or clinics whose exemption was denied because of the presence of private benefit are William H. Kenner, 20 CCH TAX CT. MEM. 185 (1961), *aff'd*, 318 F.2d 632 (7th Cir. 1963); Maynard Hosp., Inc., 52 T.C. 1006 (1969); John J. Cranley, Jr., 20 CCH TAX CT. MEM. 20 (1961); *see also* Hassett v. Assoc. Hosp. Serv. Corp., 125 F.2d 611 (1st Cir.), *cert. denied*, 316 U.S. 672 (1942), where the organization was treated as operated for the private benefit of its subscribers and did not make its services available to all persons in the community able to pay.

[99] "Another area of concern which has implications, not only for Medicare and Medicaid, but also for the tax collector, involves a trend toward changing the status of a proprietary health care facility to that of a 'nonprofit' institution." REPORT OF THE STAFF TO THE COMM. ON FINANCE, U.S. SENATE, MEDICARE AND MEDICAID: PROBLEMS, ISSUES AND ALTERNATIVES, 91st Cong., 1st Sess. 140 (1970). This longstanding concern accounts for the thrust of litigation in the Federal courts questioning the tax exempt status of institutions converting from proprietary to nonprofit status because of the continuation of private benefits.

Robert C. Olney, 17 CCH TAX CT. MEM. 982 (1958) and *Davis Hospital, Inc.*, 4 CCH TAX CT. MEM. 312 (1945), a reasonable volume of free care enabled the hospitals to rebut the Government's claim of private benefit.[100]

In none of these cases did denial or affirmance of exemption turn primarily on the issue of free care.[101] Whenever a hospital is operated for private benefit, those controlling it normally try to minimize losses from free care in order to maximize their own private profit. The failure to provide free care in *Sonora, Lorain, Harding* and other Federal cases is merely *further evidence* that the parties controlling the hospital were operating it for their private benefit. The inescapable fact in the *Sonora, Lorain*

[100] In *Commissioner v. Battle Creek, Inc.*, 126 F.2d 405 (5th Cir. 1942), the subject hospital had been organized under the general corporation laws of Florida, rather than under the non-profit corporation laws. Its charter authorized it to conduct any lawful business. The Government argued that the organization did not qualify as being organized exclusively for charitable purposes because of the business powers authorized in its charter. The court rejected this argument and found in favor of the hospital. Furthermore, the absence of provisions dedicating the hospital's assets to charitable purposes in the event of dissolution (the organizational test) was open to attack. Failure to dedicate assets to charity makes the organization susceptible to having its assets ultimately inure to the benefit of private individuals.

The holding of the case thus relates to the organizational test, (Treas. Reg. §1.501(c)(3)-1(b)) rather than the operational test (Treas. Reg. §1.501(c)(3)-1(c)) for exemption under section 501(c)(3). *Rev. Rul. 56-185* acknowledges the proper context of this case by citing it in criteria 1. which deals with the organizational test, rather than in criteria 2. which deals with free care:

> "1. It must be organized as a nonprofit charitable organization for the purpose of operating a hospital for the care of the sick. A nonprofit hospital chartered only in general terms as a charitable corporation can meet the test as being organized exclusively for charitable purposes. See *Commissioner v. Battle Creek, Inc.* 126 Fed. (2d) 405." 1956-1 CUM. BULL. 202, 203.

[101] The only case dealing exclusively with the question of whether a tax exempt health institution may charge all persons served is *Salem Lutheran Home Assoc.*, 2 CCH TAX CT. MEM. 157 (1943), in which the tax court held the organization exempt.

and *Harding* cases is that none of those hospitals could have qualified under section 501(c)(3), regardless of the percentage of free care provided, because there was other compelling evidence that they were operated for the private benefit of a small group of physicians.

In *Intercity Hospital, Olney* and *Davis Hospital*, the presence of free care, in the absence of other evidence, rebutted the existence of private benefit or profit which would have resulted in the denial of those hospitals' exemptions. Thus, although it is appropriate to consider free care to determine the presence or absence of private benefit or profit, these cases provide neither precedent nor any meaningful guidelines for cases not involving private benefit or profit.

Even assuming, *arguendo*, that the levels of free care suggested in these cases may be relevant to the question of charitable exemption outside the context of private benefit, they are not applicable under today's conditions. *Battle Creek, Davis Hospital* and *Intercity Hospital* were decided between 1942 and 1945. The free or below cost care involved in these cases, ranging from 6% to 47%,[102] may have had some meaning for particular hospitals 30 years ago. However, in view of the changes previously discussed,[103] particularly the substantial increase in coverage

[102] In *Battle Creek*, 705 of 1,776 clinic patients were treated free and 145 paid a portion of the regular rates. Thus 47% of the patients treated were treated free or below cost. In *Davis Hospital*, the hospital "received no compensation from any source for services rendered to from 30 to 40 per cent of the patients admitted to and treated in its hospital." In *Intercity Hospital Assoc.*, "an amount ranging from six to eight per cent, of such gross income was donated to charity patients." The above figures also illustrate another facet of these earlier Federal decisions. There is such a wide variation in the range of percentages of free care suggested in these cases that no ascertainable standards can be found. As discussed in Section VI, *infra* this is one of the reasons which compelled the Commissioner to issue *Rev. Rul. 69-545* to modify *Rev. Rul. 56-185*.

[103] See Section II, *supra*.

of the population by some form of health insurance, the levels of free care suggested in earlier cases should have no bearing on the Court's consideration of the criteria for exemption of today's hospitals.[104]

In summation, Federal case law dealing with the tax-exempt status of nonprofit hospitals is distinguishable because those cases primarily involve the issue of private benefit, or as in the *Battle Creek* case, the failure to comply with the formalities of the organizational test (which could result in private benefit). In any event the free care analysis extrapolated by plaintiffs from these cases is outmoded. Thus, the language in these cases pertaining to percentage of free care should have no bearing on the issue before the Court.

B. Rev. Rul. 69-545 Follows the Approach Taken in Federal Case Law.

As indicated above, Federal case law requires a consideration of all pertinent factors to determine the exempt status of a nonprofit hospital. The IRS has followed this approach in its revenue rulings. A two-part test, requiring both a charitable purpose and the absence of private benefit or profit, was initially stated in *Rev. Rul. 56-185*, which defined the term "charitable" as contemplating "an implied public trust constituted for some public benefit, the income or beneficial interest of which may not inure

[104] "Hospital expenses per patient day have increased over 700% since 1946, rising especially rapidly the last several years. . . . Among factors contributing to the rise in hospital expenses are technological changes, increased demand, and rising costs of labor and supplies. . . . The public also demands more—a large number of more costly services—from the hospital now than it did two decades ago because of rising income, increasing insurance coverage, and changing demographic characteristics of the population."

BASIC FACTS ON THE HEALTH INDUSTRY, HOUSE COMM. ON WAYS AND MEANS, 91st Cong., 1st Sess. 52 (1971).

to the benefit of any private shareholder or individual."[105]

Rev. Rul. 69-545 continues this two-part test.[106] Although the promotion of health in a manner beneficial to the community is posited as the charitable purpose, guidelines are set forth for situations which involve private benefit. In fact, the discussion in the Ruling of Hospital *B*, which is denied exemption under section 501(c)(3) because of the presence of private benefit, has generally been ignored. It is this very distinction between hospitals operated for the benefit of the public and those operated for private interests, illustrated in *Rev. Rul. 69-545* by Hospitals *A* and *B*, respectively, which has consistently been the gravamen of decisions rendered in Federal cases involving tax exempt hospitals. This concern for both facets of the test of charitable status makes *Rev. Rul. 69-545* consistent with Federal case law.

IV. REV. RUL. 69-545 IS CONSISTENT WITH FEDERAL HEALTH POLICY.

Plaintiffs' contention that "Federal health policy presupposes and requires that nonprofit hospitals provide free care to the indigent" is inaccurate.[107] No such Federal policy exists.

[105] *Rev. Rul. 56-185* places strong emphasis on the "private benefit" problem in its third and fourth criteria. It also states that "a hospital formed by one or more physicians in a community who may own the capital stock thereof or rent the hospital facilities to a corporation which they control requires careful study to determine whether it is being operated in part to serve their interest, directly or indirectly." 1956-1 CUM. BULL. 202, 204.

[106] "These factors indicate that the use and control of Hospital *A* are for the benefit of the public and that no part of the income of the organization is inuring to the benefit of any private individual nor is any private interest being served." 1969-2 CUM. BULL. 117, 118.

[107] Pl. Br. at 38.

The Federal government has long recognized the importance of adequate health care for all. However, Federal policy is directed towards achieving this goal by providing reimbursement for health services for persons unable to pay, rather than by imposing an obligation upon health care providers to supply free care.[108] Medicare and Medicaid, 42 U.S.C. §1395-1396, provide the clearest and most significant expression of this Federal policy of upgrading the health care of all citizens by providing the suppliers of such care with reimbursement from federal, state and private sources.

The various legislative proposals for national health insurance introduced during the 93rd and 94th Congress further illustrate the Federal reimbursement policy. None of these bills contain any obligation on the part of hospitals to provide free care. They do, however, recognize that the Federal government should guarantee adequate health care for all by assuming the cost of hospital insurance for those unable to pay.[109]

As evidence of an alleged Federal free-care policy, plaintiffs refer to the obligation to provide indigent care imposed upon recipients of construction grants under the Hill-Burton Program and its successor, the National Health

---

[108] "The American tradition has been to make hospitals as nearly self-supporting as possible, and the present trend seems to be to make governmental aid to hospitals available on the basis of individual patient service for those who cannot pay, in order to preserve the practice which has been so effective in the development of a superior hospital service." COMM'N ON HOSPITAL CARE, HOSPITAL CARE IN THE UNITED STATES 537-39 (1947).

[109] See the major proposals introduced during the 93rd and 94th Congress: H.R. 1, 94th Cong., 1st Sess. (1975) (The Ullman Bill); S. 3, 94th Cong., 1st Sess. (1975) (The Kennedy-Griffiths Bill); S. 33286/H.R. 3870, 93rd Cong., 2nd Sess. (1974) (The Kennedy-Mills Bill); S. 44/H.R. 2222 (Hansen-Broyhill-Fulton Bill); S. 2513, 93rd Cong., 2nd Sess. (1974) (Long-Ribicoff Bill); and H.R. 12684/S. 2970, 93rd Cong., 2nd Sess. (1974) (Mills, Schneebeli-Packwood Bill).

Planning and Resources Development Act of 1974, 42 U.S.C. 291 *et seq.* (collectively referred to as the "Hill-Burton Program"). Rather than being evidence of a Federal free-care policy, however, the Hill-Burton Program is actually a further example of Federal reimbursement policy. As under Medicare and Medicaid, the Federal government is really purchasing services for the poor, although under the Hill-Burton Program payments are made in advance of, rather than subsequent to, the rendition of services.[110]

In any event, grants made under the Hill-Burton Program represent only a small part of the government's overall health program. A comparison of (a) government expenditures for reimbursement to health care providers under Medicare and Medicaid to (b) amounts expended under the Hill-Burton Program evidences an overwhelming commitment to a Federal reimbursement policy. For example, in 1974 the Federal government spent 125 times more on reimbursement for health services than it spent on grants under the Hill-Burton Program.[111]

---

[110] This obligation to provide a reasonable volume of services to persons unable to pay has been held to be a contractual obligation arising out of the receipt of Federal funds under the Hill-Burton Program. *E.g.*, Euresti v. Stenner, 458 F.2d 1115 (10th Cir. 1972); Corum v. Beth Israel Medical Ctr., 359 F. Supp. 909, 912 (S.D. N.Y. 1973).

[111] In 1974 the Government spent $11,321,900,000 on Medicare payments and $11,218,400,000 on Medicaid payments for a total expenditure of $22,545,300,000. Worthington, *National Health Expenditures, 1929-1974*, 38 SOC. SEC. BULL. 3, at 10 Table 3 (Feb. 1975). On the other hand, government appropriation for health facilities construction under the Hill-Burton Program during 1974 was only $120,000,000. U. S. DEPT. OF HEW, PUBLIC HEALTH SERVICES, HEALTH FACILITIES CONSTRUCTION: BY TYPE OF FUNDS (1920-1974) (HILL-BURTON FEDERAL GRANTS).

V. REV. RUL. 69-545 IS CONSISTENT WITH THE LEGISLATIVE HISTORY OF SECTION 501(c)(3)

The Revenue Act of 1894 (Act of Aug. 15, 1894, ch. 349, 28 Stat. 553) was the first Federal act to impose a tax on the income and profits of corporations generally. The Act also contained the first exemption provision, the language of which has generally been used in every subsequent income tax law:

> "That nothing herein contained shall apply to . . . corporations, companies, or associations organized and conducted solely for charitable, religious, or educational purposes, . . . " Act of Aug. 15, 1894, ch. 349, §32, 28 Stat. 553, 556.

This exemption provision was enacted without debate and virtually without comment. Congressman Tucker, in offering the amendment providing for the exemption, stated merely that it was intended to assure that "educational and charitable institutions may not suffer under the bill."[112]

The income tax of 1894 was declared unconstitutional,[113] but in 1909 Congress enacted an excise tax upon corporate income which carried over the substance of the 1894 exemption provision. Act of August 5, 1909, ch. 6, §38, 36 Stat. 11, 113. This exemption, introduced by Senator Bacon, exempted from tax those associations

> "organized and operated for religious, charitable or educational purposes, no part of the profit of which inures to the benefit of any private stockholder or individual, but all of the profit of which is in good faith devoted to the said religious, charitable, or educational purposes." 44 Cong. Rec. 4151 (1909).

The only meaningful discussion of the 1909 exemption was offered by Senator Bacon during the Senate debate:

> "It occurred to me that in this partial levy of tax, where we are seeking to reach a certain class of wealth, we very properly except those institutions and those enterprises which have no element of personal gain in them whatever, and which are devoted exclusively *to the relief of suffering, to the alleviation of our people, and to all things which commend themselves to every charitable and just impulse.*" 44 Cong. Rec. 4150 (emphasis supplied).

This language does not indicate any attempt to limit the charitable exemption to organizations relieving poverty, but rather points to the broader "humanitarian approach" which recognizes the social benefits attendant to all forms of relief of distress upon which charitable exemptions in general, and *Rev. Rul. 69-545* in particular, are based.

In 1913 the Constitution was amended and Congress re-established the income tax in the Act of October 3, 1913, ch. 16, 38 Stat. 114, carrying over the exemption provisions of the corporation excise tax of 1909. *Id.* at §II.G.(a), 38 Stat. 114, 172.

The first legislative history specifically relevant to income tax exemption of hospitals is found in connection with the interpretation of an analogous section of the Social Security Act of 1935, when an amendment was proposed to add hospitals to the class of exempt organizations "organized and operated exclusively for . . . charitable . . . purposes" under that Act. Section 210(b)(7) of the Social Security Act.[114] The Statement of the Managers on this amendment illustrates Congress' recognition that the term "charitable" in section 501(c)(3) includes nonprofit hospitals.

---

[112] 26 Cong. Rec. 1727 (1894).

[113] Pollack v. Farmers' Loan & Trust Co., 157 U.S. 429, *aff'd on reh.*, 158 U.S. 601 (1895).

[114] Social Security Act, Title II, ch. 531, §210(b)(7), 49 Stat. 620, 625 (Aug. 14, 1935), as amended, Social Security Act Amendments of 1939, Title II, ch. 666, §209(b)(8), 53 Stat. 1360, 1374 (Aug. 10, 1939).

> "The Senate amendment adds to the list of purposes 'or hospital' as a clarifying amendment. The Senate recedes, the conferees omitting this language as surplusage, based on the fact that the Internal Revenue Bureau has uniformly construed language in the income tax laws, identical with that found in the House bill, as exempting hospitals not operated for profit, and also on the fear that the insertion of the words added by the Senate amendment might interfere with the continuation of the long-continued construction of the income tax law." H.R. REP. No. 1540, 74th Cong., 1st Sess. 7 (1935).[115]

Plaintiffs, however, refer to two other instances of Congressional inaction as alleged support for their position that nonprofit hospitals must relieve poverty as a condition of their charitable status under section 501(c)(3). The first relates to a 1924 Senatorial consideration of an amendment to section 214(a)(11) of the Revenue Acts of 1918 and 1921,[116] which was the predecessor of section 170(c)(2)(B) and which had purportedly been interpreted in I.T. 1800[117] Pl. Br. at 25.

In I.T. 1800 the Commissioner appeared to reject various legal definitions of the term "charitable" in favor of the position that the term "charitable" should be used in its popular and ordinary sense which allegedly pertained to the relief of poverty.[118] The proposed amendment was to define "charitable" purposes in section 214(a)(11) to in-

[115] Providing further support, the Attorney General of the United States has stated that "the history clearly shows that the language of the [charitable] exemption in the [Social Security] statute was adopted by Congress with knowledge that it has been construed to include nonprofit hospitals." 40 OP. ATT'Y GEN. 286 (1947).

[116] Rev. Act of 1918, ch. 18, 40 Stat. 1057 (Feb. 24, 1919); Rev. Act of 1921, ch. 136, 42 Stat. 227, 241 (Nov. 23, 1921).

[117] I.T. 1800, II-2 CUM. BULL. 152 (1923).

[118] *Id.* at 153; see also the discussion of the lack of legal validity of the separateness theory, Reiling, *Federal Taxation: What Is a Charitable Organization?*, 44 A.B.A.J. 525, 527-28 (1958).

clude "preventive and constructive service for relief, rehabilitation, health, character building, and citizenship" purposes.[119]

Plaintiffs attempt to infer a Congressional intent to require hospitals to relieve poverty as a condition to charitable status from the subsequent abandonment of this proposal on the Senate floor. Such an inference is without support for two reasons. First, the "relief of poverty" interpretation *by the Commissioner* apparently contained in I.T. 1800 has long since been rejected and obsoleted,[120] and I.T. 1800 was specifically overruled by Income Tax Regulation §1.501(c)(3)-1(d)(2).[121] This simply illustrates that the Commissioner has the unquestioned authority to change his interpretation and still adhere to the intent of section 501(c)(3).[122]

Secondly, as Senator Willis specifically stated, the amendment was introduced "in order to draw the attention of the Senate to the dangerous situation in which the *community-chest funds* will be if the bill shall pass in its present form."[123] Since its specific purpose was to permit community-chest funds to operate for the purpose enumerated in the proposed amendment, its subsequent abandonment by Congress is meaningless as evidence of any Congressional intent with respect to the tax-exempt status of nonprofit hospitals.

The other instance of legislative inaction asserted by plaintiffs as supporting their position involved the elimi-

[119] 65 Cong. Rec. 8171 (1924).

[120] Declared obsolete in Rev. Rul. 69-43, 1969-1 CUM. BULL. 310, *modified in* S.M. 2160, III-2 CUM. BULL. 151 (1924). Sol. Op. 159, III-1 CUM. BULL. 480 (1924); *see also* Isabel Peters, 21 T.C. 55 (1953), *acquiescence in* Rev. Rul. 59-310, 1959-2 CUM. BULL. 146.

[121] T.D. 6391, 24 Fed. Reg. 5217 (1959).

[122] Section 7805 of the Code.

[123] 65 Cong. Rec. 8171 (1924) (emphasis supplied).

nation of a proposal from the Tax Reform Act of 1969 to specifically exempt under section 501(c)(3) organizations organized and operated exclusively for providing hospital care. Pl. Br. at 25-28. The initial Bill, H.R. 13270, as reported out of the House, provided for the exemption of organizations which are "organized and operated exclusively for the providing of hospital care."[124] The principal reason for this proposal was the "significant uncertainty as to the extent to which a hospital must accept patients who are unable to pay, in order to retain its exempt status," and the proposal was designed to remove "such uncertainty by establishing hospitals as a separate exempt category. . . ."[125]

Prior to consideration of H.R. 13270 in the Senate, the Senate Committee on Finance instructed its staff to summarize the various provisions in the Bill and to describe the major arguments for and against the House amendments to the Bill.[126] One argument in the summary against the Bill was:

> "(7) Since the need for new legislative language has arisen because of uncertainties in administration, then the resolution of such uncertainties could be handled on an administrative basis."[127]

Thereafter, apparently in response to the suggestion in this argument, the IRS promulgated *Rev. Rul. 69-545* which set forth more administrable standards for exemption of nonprofit hospitals. Since *Rev. Rul. 69-545* eliminated any uncertainty with respect to the administrative

[124] H.R. 13270, §§101(j) and 201(a), 91st Cong., 1st Sess. (1969).

[125] H.R. Rep. No. 91-413 (Part I), 91st Cong., 1st Sess. 43 (1969).

[126] Report of the Staff of the Comm. on Fin., Medicare and Medicaid: Problems, Issues and Alternatives, 91st Cong., 1st Sess. 55 (1970).

[127] Summary of H.R. 13270, The Tax Reform Act of 1969 (as passed by the House of Representatives), 91st Cong., 1st Sess. 24 (1969).

standards applied under former Rulings, the need for remedial legislation had become moot.[128] The Senate Finance Committee then deleted the hospital exemption from H.R. 13270.

Contrary to plaintiffs' argument, the language in the Senate Report[129] does not indicate a Congressional opinion that *Rev. Rul. 69-545* was contrary to the charitable provisions of section 501(c)(3). It is not possible to tell from the language in the Report whether the Committee, after the suggestion of its own staff that this matter be handled administratively, acted because it thought the hospital care amendment was unnecessary, in view of the publication of *Rev. Rul. 69-545*, or was undesirable.

Under such circumstances, "the failure of Congress to amend the statute is without meaning for purposes of statutory interpretation." *Order of Ry. Conductors v. Swan*, 329 U.S. 520, 529 (1947). Congressional silence is almost always a weak and hazardous basis for interpretation.[130] This is especially true since the term "charitable," as used in section 501(c)(3), is required to be defined in accordance with its generally accepted legal sense as developed by judicial decisions. As the courts have observed "[when] a statute is subjected to the interpretation of the courts, too much weight should not be given to the language contained in discarded meas-

[128] It is noted that although *Rev. Rul. 69-545* contained narrower standards, i.e., open emergency room, care of Medicare and Medicaid patients, publicly controlled governing body, absence of private benefit etc., than originally contemplated under the legislation proposed by the House, it nevertheless offered a set of definite and administrative standards that both the hospitals and IRS could follow. For this reason, the need for the proposed remedial legislation became moot.

[129] S. Rep. No. 91-552, 91st Cong., 1st Sess. 61 (1969).

[130] American Trucking v. A.T. & S.F.R.R., 387 U.S. 397, 417-18 (1967); Red Lion Broadcasting Co. v. F.C.C., 395 U.S. 367, 382 n. 11 (1969); Zuber v. Allen, 396 U.S. 168 (1969).

ures or to the statements of legislators in the course of debate."[131]

VI. THE ISSUANCE OF REV. RUL. 69-545 WAS REQUIRED BY THE AMENDED 1959 TREASURY REGULATIONS AND BY RELEVANT ADMINISTRATIVE CONSIDERATIONS.

A. Treasury Regulations Promulgated in 1959 Recognized Broad Concepts of Charity and Required Revision of Rev. Rul. 56-185.

Following the enactment of the new Internal Revenue Code of 1954, the Treasury Department undertook to issue new regulations under section 501(c)(3). The regulations, in effect at the time *Rev. Rul. 56-185* was issued, defined "charitable purposes" as follows:

> "Corporations organized and operated exclusively for charitable purposes comprise, in general, organizations for the relief of the poor." Treas. Reg. 118, §39.101(6)-1(b) (1953).

Proposed regulations, initially issued in 1956,[132] basically repeated this restrictive view of charity, but were withdrawn while a more thorough study was made. The first comprehensive set of regulations interpreting section 501(c)(3) were proposed early in 1959[133] and, after a public hearing, "final" regulations were issued in 1959.[134]

---

[131] Jefferson v. United States, 178 F.2d 518, 520 (4th Cir. 1949), *aff'd sub nom.* Feres v. United States, 340 U.S. 135 (1950).

[132] 21 Fed. Reg. 460 (1956).

[133] 24 Fed. Reg. 1431 (1959).

[134] T.D. 6391, 24 Fed. Reg. 5217 (1959). The regulations proposed in 1956 indicated that the fact "that a hospital may require payments for services from those able to pay, will not necessarily preclude exemption." Proposed Treas. Reg. §1.501(c)(3)-1(b), 21 Fed. Reg. 460, 464 (1956). Although these proposed regulations were subsequently withdrawn in favor of

(Footnote continued on following page)

The key provision of the regulations, §1.501(c)(3)-1(d)(2), reads as follows:

> "(2) *Charitable defined.* The term 'charitable' is used in section 501(c)(3) in its generally accepted legal sense and is, therefore, not to be construed as limited by the separate enumeration in section 501(c)(3) of other tax-exempt purposes which may fall within the broad outlines of 'charity' as developed by judicial decisions. Such term includes: relief of the poor and distressed or of the underprivileged; advancement of religion; advancement of education or science; erection or maintenance of public buildings, monuments, or works; lessening of the burdens of Government; and promotion of social welfare by organizations designed to accomplish any of the above purposes, or (i) to lessen neighborhood tensions; (ii) to eliminate prejudice and discrimination; (iii) to defend human and civil rights secured by law; or (iv) to combat community deterioration and juvenile delinquency."

These regulations recognize that the term "charity" is not limited to "relief of poverty," but encompasses a broad concept of community benefit or public interest as discussed in Section I above. Accordingly, the Commissioner was required to re-examine *Rev. Rul. 56-185* issued three years earlier under the prior regulations because the relief of poverty requirement in *Rev. Rul. 56-185* was inconsistent with the 1959 regulations.[135] Thus, the issu-

---

(Continued from previous page)

the even broader view of charity expressed in the 1959 regulations, Treas. Reg. §1.501(c)(3)-1(d)(2), the public was put on notice of a shift in the attitude of the IRS toward a more liberal view of tax exemption of nonprofit hospitals and was afforded an opportunity to comment on this subject.

[135] In issuing interpretative rulings under section 501(c)(3), the Commissioner was bound to consider the rule construction in *Helvering v. Bliss*, 293 U.S. 143, 150-51 (1934) that the "exemption of income devoted to charity and the reduction of the rate of tax on capital gains were liberalizations of the taxpayer's favor, were begotten from motives of public policy, and are not to be narrowly construed."

ance of *Rev. Rul.* 69-545 was not an arbitrary act by the Commissioner; it was compelled by law and regulations, with adequate opportunity for public comment and hearings.[136]

B. Modification of Rev. Rul. 56-185 Was Required for Sound Administrative Reasons.

Rev. Rul. 56-185 contained serious administrative inadequacies which necessitated amendment. In the first place, the Ruling is confusing and internally inconsistent. Although primarily relying on relief of poverty, *Rev. Rul. 56-185* also admits of other broader grounds for exemption of nonprofit hospitals. It states that a hospital may be exempt under section 501(c)(3) because it is "organized and operated primarily for educational, scientific, *or* public charitable purposes," indicating a recognition that there are other reasons for exempting a hospital besides its ability to render free care. Thus, under the 1956 Ruling, nonprofit hospitals could be exempt by conducting medical education, training or research, thereby benefiting mankind even though they may be unable to provide free care. Such confusion created difficulties in its application and led to challenges and uneven administration.

---

[136] It should be especially noted that the regulations promulgated in 1959 resulted from a prolonged study within the Treasury Department of the existing law, views reflected in written comments, and public hearings on the proposed regulations. The opportunity for public hearing on the proposed regulations afforded all persons concerned an opportunity to express to the appropriate adminstrative officers their views on the same issues now before the Court because once the regulations, embodying the broad definition of the law of charity, were proposed, *Rev. Rul. 56-185* with its narrow view of charity was brought into question. After the regulations were finalized, the Commissioner was required to revise and change the relief of poverty requirement as a *sine qua non* to exemption in *Rev. Rul. 56-185* to conform with the new regulations.

Second, the test set forth in the 1956 Ruling for operating in furtherance of "public charitable" purposes (as opposed to "educational" or "scientific" purposes) is itself difficult to administer. This test requires an exempt hospital to operate "to the extent of its financial ability for those unable to pay," and the difficulty in administering this test is highlighted by the number of significant internal modifications in the Ruling.[137]

For example, although many hospitals realize an annual surplus or "profit" for accounting purposes, such superficial appearance of "financial ability" to provide indigent care can be illusory because such accounting is unrelated to cash needs for such matters as debt service.[138] Hospitals with a more favorable cash flow may need those funds for renovation or modernization of obsolescent facilities, the purchase of new equipment, or to implement

---

[137] *Rev. Rul. 56-185* modifies the "financial ability" standard as follows:

> "The fact that its charity record is relatively low is not conclusive that a hospital is not operated for charitable purposes to the full extent of its financial ability. . . . It may also set aside earnings which it uses for improvements and additions to hospital facilities.
>
> . . .
>
> "A nominal charity record for a given period of time, in the absence of charitable demands of the community, will not affect its right to continued exemption." 1956-1 CUM. BULL. 203-04.

The lack of any clear standards generated controversies similar to those found in ad valorem litigation, such as whether bad debts, unreimbursed portions of the cost of caring for Medicaid patients, and Medicare losses and disallowances constitute "charity" or "free care." *See* Jackson County v. State Tax Comm'r, 521 S.W.2d 378, 384 (Mo. 1975); *AHA Statement*, HEARINGS ON H.R. 13270 BEFORE HOUSE COMM. ON WAYS AND MEANS, 91st Cong., 1st Sess. (1969).

[138] "[The hospital] utilizes any profits for purposes that will better enable it to function as a hospital and nurses' training school. This is because profits are used for debt retirement, plant expansion, and modernization of facilities. . . . " Duncan v. Steeper, 17 Wisc. 2d 226, 235, 116 N.W.2d 154, 158 (1962).

new medical procedures or training programs.[139] Many existing facilities have serious deficiencies in terms of patient and personnel safety, functional adequacy, overall quality and accessibility, which result in a constant demand for capital to remedy these problems.[140]

Because of these competing demands on hospital funds, the financial ability test of *Rev. Rul. 56-185* pits the judgment of revenue agents against those of hospital administrators, boards of trustees, and local health planning agencies as to the allocation of funds between indigent care and all other community priorities.[141]

---

[139] Capital needs of hospitals today have shifted from construction of new hospitals to renovation and modernization of existing facilities. "The primary [reason] is the inevitable obsolescence of facilities. Advances in medical science demand development of more sophisticated accommodations, such as intensive care and/or cardiac care units. Evolutions in the patterns of care demand less sophisticated facilities, such as extended care beds and enlarged or renovated ambulatory care departments. Technological advances in the ancillary services also required that these departments be brought up to date." Editorial Note, *Renovation Projects Swell Total Hospital Construction*, 48 HOSPITALS 51 (Feb. 1, 1974).

[140] "[B]ecause of technological and physical obsolescence, there is substantial expense in simply staying even." Pierson, *An Examination of Obsolescence*, 48 HOSPITALS 52 (Feb. 1, 1974).

[141] If plaintiffs' position of free care were adopted, the total financial burden on hospitals, in exchange for tax exemption under section 501(c)(3), would be enormous. As Professor Cantor points out, this raises the question of whether such a burden would constitute an unconstitutional taking within the purview of the Fifth Amendment.

> "Yet fiscal integrity remains an important consideration in determining whether a hospital should be compelled to service indigent patients. The economic burden might be great enough to invoke complaints of an unconstitutional 'taking'; at the very least, the expense would have a substantial enough impact on a hospital's ability to function to warrant careful consideration. These factors assume even greater importance when it is considered that hospitals, unlike governmental bodies, do not possess the taxing power necescary to distribute 'public interest' burdens over the general population. Thus, unless third-party payments from private

(Footnote continued on following page)

In an article arguing for the imposition of a common law right of access by the poor to health care, Professor Cantor acknowledged, in a realistic fashion, the type of problems that both hospitals and revenue officials faced in attempting to function under *Rev. Rul. 56-185*. Although lengthy, the following excerpt illustrates these problems:

> "[T]here are several reasons why the threat to fiscal integrity from a common law right of access cannot be ignored. In the first place, even if reallocation of internal resources rather than insolvency would be the product of the proposed common law obligation, courts must be hesitant to mandate that result. There is no assurance that resources for patient care would not be diverted from *needed* expansion or *necessary* research. Arguably, '[h]ospitals should to a great extent be free to allocate their money according to a scheme which they in good faith believe will produce the greatest good for the greatest number of patients.' Nor can it be automatically assumed that government would fully subsidize the research and teaching potentially affected by added patient care obligations. Second, the added fiscal burden imposed by a common law right of access would probably cripple, and not just hamper, some hospitals. An urban institution which services a primarily poor population would not have the needed budgetary flexibility to absorb the burden of indigents' care. Without a comprehensive system of third-party payments—a system which Medicaid and Medicare do not yet provide—insolvency would presumably result. These various administrative problems

---

(Continued from previous page)

insurers or government benefit programs covered all patients, a situation which clearly does not exist, the fiscal burdens on private hospitals stemming from indigents' care would be a very real factor to consider in shaping any emerging common law obligation . . . . " Cantor, *The Law and Poor People's Access to Health Care*, 35 LAW & CONTEM. PROB. 901, 916 (1970).

> and issues indica[illegible] that courts would have to struggle to monitor a standard which varied the obligation of hospitals toward indigent patients according to the economic viability of particular institutions. Yet imposition of a crippling financial burden might be both unwise and constitutionally suspect.[142]

Rev. Rul. 56-185 was therefore inadequate in failing to provide realistic and ascertainable standards for administration. Its imprecise standards "resulted in significant uncertainty as to the extent to which a hospital must accept patients who are unable to pay, in order to retain its exempt status."[143] The correction of these inadequacies by the publication of *Rev. Rul. 69-545* was required as a matter of sound administration and fair treatment of the institution involved. Such needed corrective action was not an abuse of discretion by the Commissioner.

C. The Requirements of Rev. Rul. 69-545 for Providing Emergency Care and Treating Medicare and Medicaid Patients Provide a Valid Administrative Alternative to Prior Requirements for Free Care for the Poor.

As discussed above, *Rev. Rul. 69-545* was required to correct the administrative deficiencies of *Rev. Rul. 56-185*. However, the implication advanced by plaintiffs and the

---

[142] *Id.* at 916-18 (emphasis in original) cited in Mem'l Hosp. v. Maricopa County, 415 U.S. 250, 264 n. 23 (1974). In a similar vein another commentator has noted:

> "It may also be unreasonable to expect hospitals to 'pay' the cost of satisfying the public conscience by diverting its funds from other treatment programs. Hospitals should to a great extent be free to allocate their money according to a scheme which they in good faith believe will produce the greatest good for the greatest number of patients." Note, *Scarce Medical Resources*, 69 COLUM. L. REV. 620, 691 (1969).

[143] H.R. REP. No. 91-413 (Part 1), 91st Cong., 1st Sess. 23 (1969). See also the reference to this "indefinite test of to what extent the hospital must serve those who cannot pay" in the SUMMARY OF H.R. 13270, HOUSE COMM. ON WAYS AND MEANS, 91st Cong., 1st Sess. 23 (1969).

District Court below that *Rev. Rul. 69-545* has removed any obligation on the part of charitable hospitals to provide "special financial consideration" for the poor is inaccurate.

Rev. Rul. 69-545 does, in fact, provide a realistic and meaningful way by which an exempt hospital can continue to satisfy such obligations.

> "By operating an emergency room open to all persons and by providing hospital care for all those persons in the community able to pay the cost thereof either directly or through third party reimbursement [such as with the aid of public programs like Medicare and Medicaid], Hospital *A* is promoting the health of a class of persons that is broad enough to benefit the community."

Because of these two conditions, *Rev. Rul. 69-545* imposes an obligation on exempt hospitals for the benefit of the poor which is more significant than the highly subjective "financial ability" standard of *Rev. Rul. 56-185*.[144]

1. The Emergency Room Is the Most Important Means of Access to Medical Care for the Poor.

Plaintiffs have attempted to minimize the significance of the requirement that exemption under *Rev. Rul. 69-545* requires the operation of an emergency room open to all persons regardless of ability to pay.[145] However, the imposition of this requirement is a positive contribution by the IRS to insure health care for indigents when most needed.

---

[144] In this context, the Court should take notice of the fact that the provisions of emergency care and treatment of patients covered by public programs, such as Medicare and Medicaid, as criteria for determining exemption under section 501(c)(3) were spelled out in *Rev. Rul. 69-545 for the first time* and despite their importance to the provision of hospital care for the poor, were not factors considered under earlier rulings.

[145] The losses generated by most emergency rooms may have encouraged some hospitals to limit the scope of this activity. *Rev. Rul. 69-545* provides an important safeguard against this.

As indicated by Professor Cantor, "it becomes all the more important to guarantee ready access of indigent patients to emergency room facilities. The first step in this process is to remove the legal uncertainties surrounding the issue of a hospital's obligation to treat and care for genuine emergency cases."[146] *Rev. Rul. 69-545* helps remove this uncertainty.

Under normal circumstances, a person requiring hospital care is admitted by his personal physician to a hospital at which he has staff privileges. However, this does not usually apply in the case of the poor. They rarely have a personal physician, but instead are dependent upon the emergency room of their local hospital and, if available, its out-patient clinic. The emergency room is often the only available health resource for the poor,[147]

[146] Cantor, *The Law and Poor People's Access to Health Care*, 35 LAW & CONTEM. PROB. 901, 911 (1970).

[147] "Finding a physician and getting health care is particularly difficult for families who change communities. A significant portion of these are poor. When health needs become critical, families that do not have adequate financial resources may find emergency rooms and outpatient clinics of general hospitals the only available resource. These families, along with *poor* families, *who often have no other alternative*, have contributed to the 150 million emergency room and outpatient visits in 1967, an increase of 250% during the past two decades." NATIONAL ADVISORY COMM'N ON HEALTH FACILITIES: A REPORT OF THE PRESIDENT 20 (1968) (emphasis supplied).

" . . . the ambulatory care facilities [i.e., emergency services] of the urban general hospital constitute a major medical care resource for the economically deprived, 'core city', minority population groups." *Medical Care in Transition*, 3 AM. J. PUBL. HEALTH 414 (1966).

"A significant phenomenon of contemporary medical care is the evolution of the hospital emergency room into a full-fledged outpatient clinic. Such facilities have become, in effect, twenty-four-hour dispensaries—the place of first resort for an entire spectrum of problems from the coughing child to the critically injured accident vicitim.

"Along with centralization of care, the public must deal with the pressing shortage of physicians, the disappearance

(Footnote continued on following page)

and this utilization of emergency rooms by the poor generally results in their operation at a substantial loss.[148]

Accordingly, the maintenance of emergency facilities by tax-exempt hospitals has been recognized for some time as an important factor in determining their charitable status.

> "The hospitals probably need treat no set number of indigent patients; they can bill all patients and may attempt to collect from all patients. However, the institution's tax exemption is in jeopardy if it refuses emergency hospitilization or treatment to anyone solely because of an inability to pay."[149]

In *City of Palestine v. Missouri Pacific Hospital Association*, 99 S.W.2d 311, 314 (Tex. 1936), the court considered the emergency room facilities in concluding the hospital to be charitable.

> "From time to time emergency cases have been and are being brought to said hospital in physical condition requiring immediate treatnent to save life or prevent further serious physical injury. Regardless of race, creed, financial condition, or any other ground

(Continued from previous page)

of the traditional family doctor, and the disinclination of physicians to make house calls. Moreover, the schedules of medical offices and outpatient departments do not usually coincide with the needs of the working poor."

Cantor, *supra* at 910.

[148] HOYT, CONDITION CRITICAL: OUR HOSPITAL CRISIS 208 (1966):

"One point of loss was the emergency room, and this was true of every hospital that offered emergency services to its community . . . almost half of the emergency room's income was never collected. This was typical; in a check by the Illinois Hospital Association in 1964 the Chicago hospitals reported that they had failed to collect between a third and a half of their emergency room billings."

[149] Horty, *How Does Surplus Affect Tax Status*, 107 MOD. HOSP. 40, 40-42 (July 1966); HOSPITAL LAW MANUAL, *Taxation—State* I:26 (1973).

> or distinction, no such case has ever been turned away from such hospital. . . .[150]

Similarly in *City of Natchez v. Natchez Sanitarium Benevolent Association*, 2 So. 2d 798, 799 (Miss. 1941), the court stated:

> "Under modern conditions, especially as respects serious personal injuries, now happening with more frequency than in the past, it is important in the public interest that persons so injured or taken suddenly and seriously ill shall be immediately treated and cared for at the nearest hospital which may be reached. . . and that a person thereafter found unable to pay shall not be turned out on that account."

Thus, *Rev. Rul. 69-545* continues to impose an important obligation on tax-exempt hospitals to care for those unable to pay, but in different and more meaningful terms than contained in *Rev. Rul. 56-185*.

In addition to understating the importance of emergency room facilities to the poor, plaintiffs have at the same time attempted to obfuscate a significant aspect in the delivery of hospital care, namely, *the fact that indigents are not denied access to in-patient hospital care*. It must be recognized that state, county and municipal hospitals are available to serve indigents and, in fact, were established and are maintained by the various levels of government with taxpayers' money for only one purpose—to provide in-patient hospital care for those unable to af-

---

[150] Two of the factors leading the court to reach a favorable decision on tax-exempt status of the hospitals in *Jackson County v State Tax Comm'n.*, 521 S.W.2d 378, 383 (Mo. 1975) were:

> "(a) '8. Each of the hospitals operates emergency facilities on a 24-hour basis.';
>
> "(b) '10. No one requiring emergency treatment has ever been denied it by any of the hospitals for financial reasons.' "

These findings were dispositive of the question posed by the court: "Do the poor have meaningful access to the facilities of St. Luke's, Baptist or Research?" *Id.*

ford it elsewhere.[151] Plaintiffs Hunter, Cook and Lampton (referred to in Pl. Br. at 36) were all receiving care at Charity Hospital at the time they became dissatisfied and sought care from other institutions.[152]

Hopefully, national health insurance, when enacted, will remedy this situation and provide funds to permit all persons their choice of hospital care. However, until that time, our health system provides hospital care in voluntary nonprofit hospitals for the over 96% of the public able to pay the cost thereof, either directly or through some form of health insurance. These institutions are supported by receipts from paying patients and contributions from a public interested in community hospitals providing the highest quality of health care.

At the same time, those unable to pay have access to state, county and municipal hospitals which are supported by taxes paid by the same public whose contributions support the community's voluntary hospitals. Any substantial alteration of this system, if it is not to threaten the financial solvency of up to 3,000 voluntary nonprofit hospitals, should come about through expanded governmental funding of health care for poor by the enactment of a national health insurance program and not by a reversal of the Court of Appeals decision. Such reversal would be tantamount to a judicially enacted national health insurance program, without funding, and would risk widescale financial insolvency in many of our hospitals.[153]

---

[151] 1973 AHA GUIDE TO HEALTH FIELDS (Aug. 1973).

[152] Similarly, plaintiffs' chart indicating medium size communities not served by public hospitals (Pl. Br. App. 17A) is deceptive in its implication that hospital care is not available to indigents in communities not served by public hospitals. Except for one questionable reference to a single Kentucky Hospital, there is no evidence in the record to support the implication that voluntary hospitals in communities lacking public institutions do not treat persons unable to pay.

[153] See pp. 47-53 *supra*.

2. Access to Hospital Care Through Medicare and Medicaid Is Important to Persons Below the Poverty Level.

The requirement of *Rev. Rul. 69-545* that services be provided for all persons in the community able to pay the cost thereof, either directly, through private health insurance or with the aid of public programs such as Medicare and Medicaid, is the other important means by which the Ruling carries over the obligation of exempt hospitals to serve the poor. At a time when most of the cost of indigent care is financed by governmental programs, the important question is not whether the hospital is providing unreimbursed services for the poor, but whether it is making its services and facilities available to those for whom reimbursement is provided.[154]

Medicaid is the largest single program for providing health care for the poor. In 1968 payments were made for 13,000,000 people under Medicaid. In 1973 payments rose to an estimated 23,500,000.[155] However, since available data indicates only the number of persons who actually receive Medicaid assistance, rather than the total number of persons eligible for such assistance, the actual number of persons entitled to such benefits is even larger. Effective October 1, 1975, all states will have enacted Med-

[154] There is no legal obligation upon hospitals to provide care for Medicaid patients unless they voluntarily contract to do so. *See* 42 U.S.C. §139a (a) (23) (Supp. IV, 1969). "A section of the [Medicaid] Act known as the 'freedom of choice' provision assured recipients that services could be obtained at the facility of their choice, *provided* that the facility was willing to render services to Medicaid recipients." Cantor, *The Law and Poor People's Access to Health Care*, 35 LAW & CONTEM. PROB. 901, 921 (1970) (emphasis supplied, footnote omitted). In *La Crescent Constant Care Center, Inc. v. Minnesota*, 222 N.W.2d 87 (Minn. 1974), the court held that if the resulting state levels were inadequate, the remedy of the individual vendor of medical service is to terminate its relationship with assistance patients.

[155] NUMBER OF RECIPIENTS AND AMOUNTS OF PAYMENT UNDER MEDICAID, NCCS, B-4 NCY-70, Dept. of HEW Pub. # (SRS) 73-03153.

icaid coverage, and although the eligibility levels in some states may be too low to provide universal coverage for all medically indigent persons, the program has benefited millions of poor people and is of undeniable importance to them.

The requirement for providing services to Medicare and Medicaid patients in *Rev. Rul. 69-545* is important to the poor because Medicaid and Medicare are not always economically desirable to a hospital. Although the Medicaid program theoretically requires reimbursement on the basis of cost, on occasion less than cost may be paid.[156] Furthermore, by admitting Medicaid and Medicare patients, a hospital will limit the number of patients who pay charges rather than cost, e.g., self-pay of commercially insured patients.[157]

[156] Idaho Corp. of Benedictine Sisters v. Marks, Civ. No. 1-72-169 (D. Idaho, filed Aug. 29, 1973); *see also*, La Crescent Constant Care Center, Inc. v. Minnesota, 222 N.W.2d 87 (Minn. 1974).

[157] To the extent that Medicaid patients are, in effect, treated at rates which are below cost, *Rev. Rul. 69-545* actually preserves the concept of below cost care in *Rev. Rul. 56-185*. "Any facility currently accepting Medicaid patients will contend, *and probably legitimately so*, that Medicaid reimbursement does not meet full hospital costs; these patients are therefore already being serviced 'below cost.'" Cantor, *The Law and Poor People's Access to Health Care*, 35 LAW AND CONTEM. PROB. 901, 920 (1970) (emphasis supplied).

CONCLUSION

For the above reasons *Rev. Rul. 69-545* is a valid interpretation of section 501(c)(3), and therefore the judgment of the Court of Appeals should be affirmed.

Respectfully submitted,

ROBERT S. BROMBERG
1956 Union Commerce Building
Cleveland, Ohio 44115
Attorney for American Hospital Association

Of Counsel:
JAY H. HEDGEPETH, ESQ.
BRUCE O. BAUMGARTNER, ESQ.
DOUGLAS M. MANCINO, ESQ.